

BULLETIN

AMERICAN COLLEGE OF SURGEONS



February 2001
Volume 86, Number 2

BREAST CANCER



USA

First-Class

**One
surgeon's
mission
against
cancer**

BULLETIN

AMERICAN COLLEGE OF SURGEONS



FEBRUARY 2001
Volume 86, Number 2

FEATURES

-
- | | |
|---|----------|
| Office-based surgery regulation:
Improving patient safety and quality care
<i>Jon H. Sutton</i> | 8 |
|---|----------|
-
- | | |
|--|-----------|
| Operation Argentina:
A surgical partnership across the Americas
<i>Michael J. Cornwell, MD</i> | 13 |
|--|-----------|
-
- | | |
|---|-----------|
| A reminiscence: Serendipity steers surgeon to discovery
<i>James C. Neely, MD, FACS</i> | 21 |
|---|-----------|
-
- | | |
|---|-----------|
| Statement in support of motorcycle helmet laws | 27 |
|---|-----------|
-
- | | |
|---|-----------|
| In their own words: One man's mission against cancer
<i>Ernie Bodai, MD, FACS</i> | 28 |
|---|-----------|
-

DEPARTMENTS

-
- | | |
|---|----------|
| From my perspective
<i>Editorial by Thomas R. Russell, MD, FACS, ACS Executive Director</i> | 4 |
|---|----------|
-
- | | |
|--|----------|
| Dateline: Washington
<i>Washington Office,
Health Policy and Advocacy Department</i> | 6 |
|--|----------|
-
- | | |
|--|-----------|
| Socioeconomic tips of the month
<i>Planning for retirement</i> | 31 |
|--|-----------|
-
- | | |
|---|-----------|
| The Journal page
<i>Seymour I. Schwartz, MD, FACS</i> | 48 |
|---|-----------|
-

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Front cover

About the cover...

This month's cover features the breast cancer stamp, which was recently reauthorized for sale by the U.S. Postal Service to raise funds for breast cancer research. The stamp was conceived by Ernie Bodai, MD, FACS. In his article on page 28, Dr. Bodai talks about his quest to persuade the federal government to issue the stamp and to pass legislation that will address the treatment and prevention of breast cancer and other types of carcinoma as well.

Cover image of breast cancer stamp ©USPS.

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NEWS

College leaders awarded honorary Fellowship in Royal College of Surgeons

33

Trauma and critical care meeting to be held in May

34

College delegation active at AMA House of Delegates meeting

35

Fellows may register online for Spring Meeting

36

Disciplinary actions taken

38

Surgical oncology bibliography available online

38

Trauma Motion Picture Session: Call for videotapes

39

Highlights of the Board of Regents meeting, October 20-22, 27, 2000 John P. Lynch

40

Chapter news Rhonda Peebles

46

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From my perspective

As the Bush Administration and the 107th Congress take control in Washington, DC, the American College of Surgeons will continue to diligently and assiduously follow the activities of the federal government through our Washington Office. What will happen on the health care front during the 107th Congress is difficult to predict, but Fellows can be certain that we will closely monitor developments and respond appropriately.

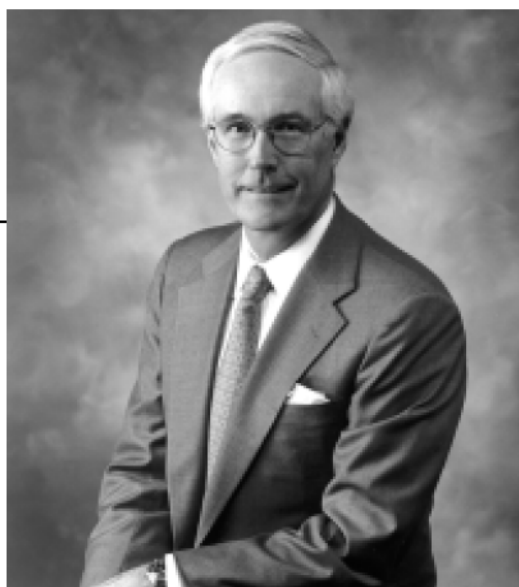
While it is important for the College to maintain its presence and influence in Washington, of perhaps equal or greater significance is having a voice in the individual state governments, which deal with a myriad of issues more regularly and, often, more quickly. I was reminded of the effects of state regulatory and legislative activity on surgical practice during my visits with some 18 chapters during the past year—effects that in many cases ultimately have an impact on surgeons throughout the country. The fact that state legislatures hold considerable sway over the practice of surgery at the local level underscores the core value of the College having 67 chapters in the United States, and that is to keep the College informed about local issues and their impact on our Fellows and their patients.

Further, our chapters are the best means we have for bringing educational programs to surgeons' "front doors" so that they can more easily and conveniently keep up with advances in surgical practice. As the College prepares to deal with the future of public policy and increasing demands for improved surgical competence, we are looking to our chapters to be a strong part of our leadership team.

Chapters and state politics

In the December 2000 *Bulletin*, I wrote about the residents' work hours issue in New York State, a problem brought to my attention during a chapter visit I made there last fall. More recently, at a New Jersey Chapter meeting I learned about new regulations in that state, which require cardiac surgeons to perform 100 open-heart operations per year in a single institution in order to be credentialed by the state.

What is particularly troublesome about the New Jersey regulations is the fact that the state is becoming involved in the credentialing of cardiac surgeons. Traditionally, the medical staffs at indi-



“As the College prepares to deal with the future of public policy and increasing demands for improved surgical competence, we are looking to our chapters to be a strong part of our leadership team.”

vidual hospitals have been responsible for verifying surgeons' qualifications through the use of objective criteria, such as education, training, board certification, and a review of their outcomes and clinical activities. The state's entry into the credentialing process seems capricious and, based on volume alone, overly simplistic and arbitrary. James Alexander, MD, FACS, the Immediate Past-President of the New Jersey Chapter, has written a strong letter to the state's Commissioner of Health and Senior Services expressing surgeons' dismay with these new regulations.

Although it may seem that the impact of these regulations would be limited to the state of New Jersey and the specialty of thoracic surgery, surgeons in other locations and specialties should be aware of this development, because situations like this one have a tendency to migrate and become issues of more global concern. The College, therefore, applauds and supports the activism that the

New Jersey Chapter has demonstrated with regard to this matter. When local chapters show concern about issues such as residents' work hours and the credentialing of surgeons, all Fellows benefit. They become aware of smoldering issues that could spread to their geographic area or surgical specialty. For instance, New Jersey's credentialing policies may apply only to cardiac surgeons today, but they could be expanded to affect other specialties in other states tomorrow. So, chapters that are very active in the political arena, as exemplified by the New Jersey Chapter, have the capacity to influence local laws and regulations, and, of equal importance, to alert chapters across the country about those issues and to share ideas and strategies for dealing with them.

In other words, advocacy on behalf of the Fellowship is an important part of the mission of the College's chapters. Through its Health Policy and Advocacy Department, the College provides issue-oriented resources, as well as advocacy materials, for use by chapters. I encourage chapter officers to contact Henry R. Desmarais, MD, MPA, director of the department, for advice on getting more involved at the state and local government levels. You can reach Dr. Desmarais by phone at 202/331-2701 or via e-mail at hdesmarais@facs.org.

Educational and outreach activities

As the demand for the College to generate more specialized and regional educational activities grows, we anticipate that our chapters will become our partners in these endeavors. In the future, we will attempt to further the educational activities of the chapters not only by granting continuing medical education credits, but also by cultivating a more active speakers' bureau. This service will ensure that Chicago headquarters staff can better coordinate and assist in planning and presenting educational meetings. I also expect the College to offer educational programs that chapters can incorporate into their meeting agendas, such as hands-on courses pertaining to new technology and workshops on practice management, ethics, and so forth.

Some chapters, such as the Metropolitan Washington Chapter, are providing models for sponsoring hands-on educational courses. That chapter, for instance, currently presents an Advanced Operative Strategies Course for chief residents. Through this program, young surgeons have the

opportunity to practice performing difficult procedures on cadavers under the supervision of local surgeons who have mastered those operations and their associated technology.

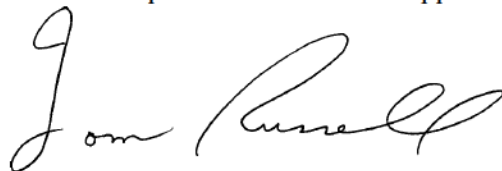
I would also like to encourage our chapters to assume a more proactive role on peer review panels, advisory committees to local Medicare carriers and other payors, and committees of other medical associations. These entities make a broad range of policy decisions that have an impact on the practice of surgery. Therefore, surgeons can play an important role in advocating on behalf of the Fellowship and their patients by working with these groups.

Preparing chapters for change

Through our Chapter Leadership Conference (previously known as the Chapter Officers Seminar), which will take place May 16-18 here at College headquarters, we hope to provide advice and support to chapter officers and administrators. Chapters that have not been especially active in the recent past need to be evaluated and perhaps rejuvenated. One way we could conceivably revitalize dormant chapters is through pilot projects or some other means that would allow them to learn from and emulate more robust and successful chapters.

In any event, I can assure you that infusing a sense of purpose and meaning into each chapter is a priority in the College's ongoing planning process, and we will do all we can to support them in their endeavors. As the chapters become more active, we anticipate that they will experience an increase not only in membership but also in relevance.

As always, your thoughts and suggestion for boosting the legislative, educational, and outreach activities of our chapters would be most appreciated.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

Dateline|Washington

prepared by the Washington Office, Health Policy and Advocacy Department

President approves \$3 million for trauma systems

During the final days of the 106th Congress, President Clinton signed a law that earmarks \$3 million in fiscal year 2001 funding for the Trauma Care Systems Planning and Development Act. This program authorizes the Secretary of Health and Human Services (HHS) to award grants to states to assist them in planning, implementing, and monitoring statewide trauma care systems.

The College will be working with both the new Bush Administration and Congress to further the goals of the original trauma program, which was administered during the mid-1990s by the Health Resources and Services Administration's (HRSA's) Division of Trauma and Emergency Medical Services (DTEMS). For example, one immediate priority will be to assist the new HRSA administrator in establishing a timely plan for administering the program and for reviewing grant applications from states and other nonprofit agencies that are eligible for funds.

HHS issues final Stark II rules

On January 4, HHS published long-awaited final regulations pertaining to physician self-referrals. The so-called Stark II law, enacted in 1995, prohibits physicians from referring Medicare patients seeking certain health care services to entities with which the physicians or their immediate family members have a financial relationship. Expanding on the original 1989 Stark law prohibiting self-referrals to clinical labs, the regulations address referrals for physical and occupational therapy, radiology and radiology therapy, durable medical equipment, parenteral and enteral nutrition, prosthetics and orthotics, home health, inpatient and outpatient hospital services, and outpatient prescription drugs. The rule is scheduled to take effect on January 4, 2002.

In addition, the Bush Administration has placed a hold on this and other regulations until they can be reviewed. The impact of this action on implementing the rules had not yet been determined at press time.

Final regs issued on medical records confidentiality

HHS also issued final regulations on December 20 that establish national standards to ensure the confidentiality of patient medical records. These comprehensive regulations were first proposed in November 1999, as mandated by the Health Insurance Portability and Accountability Act of 1996. They are scheduled to become effective in two years and will apply to all physicians, hospitals, and health insurance plans. Notably, the new rule pertains to all types of medical records including electronic, paper, and oral communications.

HHS made some changes in the final rule based on the many comments it received on the original proposal. For example, the proposed rule would have required physicians and other health care providers to abide by a "minimum necessary standard" when send-

ing medical records as part of the process of referring a patient to another physician or provider. In its comments on the proposed rule, the College argued that physicians already limit disclosures to third parties to the minimum necessary; however, if insufficient information is exchanged in some of these situations, the outcome may be detrimental to the patients' welfare. In the final rule, HHS agreed and changed the requirements to exempt physicians and providers from the "minimum necessary standard" when they are sharing patient medical records with another physician or health care provider.

More information about this extensive regulation will be published in a future issue of the *Bulletin*.

President approves Medicare give-back legislation

On December 19, President Clinton signed into law the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. The \$35 billion package provides increased Medicare funding for several provider groups and organizations, including hospitals, Medicare+Choice plans, and nursing homes. Unfortunately, BIPA provides little relief for surgeons and many other specialists, who have been facing reduced Medicare payments due to the continued phase-in of resource-based practice expense relative values into the physician fee schedule. Provisions in BIPA that are of interest to surgeons call for: a General Accounting Office (GAO) study regarding how HCFA has accepted and used actual cost data in its development of the new practice expense values; a GAO study regarding the impact of the Emergency Medical Treatment and Labor Act (so-called anti-dumping) regulations on hospitals and physicians; and a two-year freeze on scheduled reductions in payments to teaching hospitals for indirect medical education costs.

ACS adds "Legislative Action Center" to Web site

Fellows have a new tool for contacting members of Congress on issues of concern to them—the Health Policy and Advocacy Department's "Legislative Action Center," which can be accessed online at <http://congress.nw.dc.us/facs/>. This service allows Fellows to find information about members of their state's congressional delegation and other legislators on Capitol Hill, key issues that the College is tracking in Congress, and the College's latest legislative alerts. This initiative is part of an ongoing effort to increase grassroots advocacy among the Fellowship. For more information, contact cgallagher@facs.org.



Office-based surgery regulation:

Improving patient safety and quality care

by Jon H. Sutton,
*State Affairs Associate, Chicago Office,
Health Policy and Advocacy Department*

The number of surgical procedures performed in physician offices has escalated dramatically over the last 10 years. This increase is partly due to: the efforts of managed care to seek less expensive alternatives to surgical procedures performed in hospitals; new and improved surgical techniques; and technologic advances in equipment, which make operations in nontraditional settings much safer for patients. In addition, physician offices typically are not subject to the same state and federal licensing rules as hospitals and other health care facilities, making it relatively easy to open an office-based surgical practice.

While physicians have embraced the advances that have made office-based surgery safer and more convenient for the patient, the media, state-elected officials, and state regulatory agencies have not been as enthusiastic about these developments. In the September 17, 2000, edition of the *Chicago Sun-Times*, the medical editor of WBBM-Channel 2 in Chicago, IL, opined about the recent moratorium on office-based surgery in Florida discussed later in this article. He began the piece by stating, "You're likely to get your next operation right in your doctor's office; and you may be putting your life on the line as a result."¹ In its series, "Managed Care & Doctors: The Broken Promise," New York's *Newsday* published a report on the increase in numbers of office-based surgical procedures, predominantly cosmetic in nature, and resulting adverse events, including a few deaths.²

Due to these reports and the very few reported deaths in **California** and **Florida**, a small number of states have begun regulating office-based surgery. In the coming years, it is anticipated that many more states will do so, especially if any patient deaths are attributable to the procedures and the media follow up with extensive coverage.

Because most office-based surgery is fairly unregulated, it is difficult to gather statistical information—at least information that is not considered proprietary by third-party payors—on what procedures are performed in the office and how the number of these procedures increases annually. According to an article in the April 2000 issue of *The Journal of Ambulatory Care Management*, surgical procedures commonly performed in an office include liposuction, laser cosmetic surgery, breast augmentation and reduction, endoscopy, pregnancy termi-

nation, invasive radiology procedures involving sedation, colonoscopy, and microlaparoscopy.³

The American Society of Plastic Surgeons (ASPS), through its National Clearinghouse of Plastic Surgery Statistics, has compiled data from 1992 on plastic and reconstructive surgical procedures. Many of these procedures have moved into the office setting, and significant increases were experienced from 1992 to 1999 in the top three cosmetic procedures performed in the office: liposuction (389%), breast augmentation (413%), and eyelid surgery (139%).⁴

Current state regulation

Six states—**New Jersey** in 1998, **California**, **Pennsylvania**, **Rhode Island**, and **Texas** in 1999, and **Florida** in 2000—have addressed the issue of office-based surgery and have implemented regulatory requirements. Of them, California, Pennsylvania, Rhode Island, and Texas passed enabling legislation requiring the Medical Board, Department of Health, or Board of Medical Examiners to develop and implement appropriate regulatory mechanisms, including reporting requirements, accreditation and certification standards, anesthesia standards, facility and equipment requirements, safety and emergency procedures, and staffing requirements. Florida and New Jersey took the "rules and regulations" approach and, through the Board of Medicine/Board of Medical Examiners, issued a set of comprehensive regulations.

The range of regulation varies widely among these states. At one end of the spectrum, California and Texas took a more limited approach to regulating office surgery by focusing more on the number and qualifications of personnel, agreements for transferring patients to hospitals, and general requirements for the administration of anesthesia, although Texas was more specific than California in this regard. California law applies to any setting outside of a hospital and requires that each office have a written transfer agreement with a hospital, a physician/surgeon with hospital privileges, or a detailed emergency procedure approved by an accrediting agency. Liability insurance coverage is required for those procedures performed outside the hospital, and the Medical Board of California is required to develop appropriate accreditation standards (not completed at press time).

Adverse events must be reported to the Medical Board.

The Texas statute applies to an outpatient setting not part of a hospital or ambulatory surgical center where general, regional, or monitored anesthesia is administered. Excluded are outpatient settings accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), or Accreditation Association for Ambulatory Health Care (AAAHC). The statute requires that the American Society of Anesthesiologist's (ASA) standards and guidelines for office-based anesthesia be followed and mandates that anesthesia be provided by a physician or anesthesiologist or delegated to a certified registered nurse anesthetist (CRNA) under their supervision. A transfer agreement with the local emergency medical services (EMS) system is required, and adverse incidents must be reported to the Board of Medical Examiners.

At the other extreme are Florida, New Jersey, Pennsylvania, and Rhode Island, which have gone to great lengths to spell out in considerable detail requirements for anesthesia and personnel, along with type or level of surgery, facility requirements, including crash carts and equipment mandates, accreditation and certification standards, and procedures to respond to emergencies.

The New Jersey Board of Medical Examiners issued rules that incorporated anesthesia standards of care for sedation and analgesia by nonanesthesiologists as published by the ASA. While not covering minor surgical procedures, these rules are strict about appropriate provision of anesthesia and personnel administering anesthesia, equipment and supplies, safety systems and monitoring devices, and recovery area requirements. Interestingly, the New Jersey rules apply to offices with only one operating room and that are not subject to the jurisdiction and licensure requirements of the New Jersey Department of Health and Senior Services.

The Pennsylvania statute applies to ambulatory surgical facilities including that portion of a physician's office devoted to surgical procedures. There are three classes of facilities: A, B, and C, which are based on the procedure, patient status, and anesthesia administered. Class A facilities include a private or group practice where only local

or topical anesthesia is used, and while facility licensure is not required, they do have to be accredited by the JCAHO, AAAHC, or AAAASF. Class B facilities include single or multispecialty facilities where sedation anesthesia or dissociative drugs are administered and are limited to patients in ASA Physical Status (PS) 1 or 2 unless the patient's PS status would not be adversely affected by the procedure. Class B facilities must be licensed and accredited. Class C facilities include single or multispecialty facilities administering general anesthesia, and are limited to PS 1, 2, or 3 status patients. They must be licensed and accredited.

Other Pennsylvania requirements include transfer agreements with hospitals and a limit of four hours or less on the duration of surgical procedures. Anesthesia can be administered by an anesthesiologist or a CRNA, dental anesthetist, or other practitioner under the supervision of a physician, dentist, or anesthesiologist.

Rhode Island goes so far as to limit to two hours the length of surgical procedures, and any procedure exceeding that limit must be documented and reviewed. Offices must follow the ASA physical status classification, and physicians performing the procedures must have clinical privileges to perform the same procedure in the hospital. Anesthesia of most types must be administered by an anesthesiologist or a CRNA under the supervision of a qualified physician. Adverse events must be reported to the state's Department of Health. In addition, the office must be licensed by January 1, 2001, and accredited by the JCAHO, AAAASF, or AAAHC within 24 months of licensure.

In the case of Florida, these regulations were primarily based on level of anesthesia used, but also named specific procedures in the first two levels (minor procedures in Level I, such as excision of skin lesions, repair of lacerations, drainage of abscesses, limited endoscopies, and so on). After a number of hearings, these rules went into effect in February 2000. The Florida scheme includes Level I, Level II, Level IIA, and Level III office surgery, and the higher the level, the more stringent the anesthesia and personnel requirements. The state also incorporates the ASA physical status classification, and, for Level II and III office surgery, requires administration of anesthesia by an anesthesiologist, CRNA, or physician assistant. Offices using intravenous sedation or general anesthesia

must be accredited by JCAHO, AAAASF, or AAAHC, and adverse incidents must be reported to the Medical Board of Florida.

Not only were the Florida rules extensive in scope, they were also contentious, resulting in the filing of a number of lawsuits against the Florida Board of Medicine. In addition, the Board became increasingly concerned with the number of adverse outcomes (nine injuries, including five total deaths) reported to it during the period of March through July 2000. As a result, the Board issued an emergency rule on August 10, 2000, placing a 90-day moratorium on the performance of Level III surgery (procedures using general anesthesia) in physician offices.⁵

When the moratorium expired, the Board issued emergency rules effective immediately that: (1) prohibited the combination of abdominoplasty with liposuction and liposuction in combination with other surgical procedures; (2) required risk management systems in offices where Level II and III surgical procedures are performed; (3) mandated submission of surgical logs for Level II and III surgical procedures; (4) prohibited Level III procedures in office settings for ASA physical status III patients; (5) required all ASA physical status II patients over the age of 40 years to have complete medical work-up for Level III procedures in office settings; and (6) mandated compliance with ASA anesthetic monitoring guidelines.⁶

State activity in 2000

Only a few states considered legislation pertaining to office-based surgery during 2000. In a couple of cases, these bills focused on data collection with no attempt to actually regulate office surgery.

Connecticut—The General Assembly considered H.B. 5652, which would have required any unlicensed facility operated by a licensed health care practitioner or practitioner group at which moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia is administered to meet the accreditation standards of the Medicare program, AAAHC, AAAASF, or JCAHO. The Public Health Committee voted in support of H.B. 5652, but the house did not act on it before adjourning for the year.

On August 22, 2000, Connecticut's Office of Health Care Access issued a notice of intent to adopt regulations applying to office surgical pro-

cedures. Under these proposed regulations, minor surgical procedures would be exempt, as would procedures limited to the skin and subcutaneous tissues or other procedures performed under topical or local anesthesia not involving drug-induced alteration of consciousness other than minimal preoperative tranquilization. Current hospital privileges would be required of physicians performing procedures in their offices, and the duration of these procedures must be two hours or less.

Michigan—The legislature passed and the governor signed H.B. 4599. Under terms of this new law, a private physician's office where 50 percent or more of the patients annually served at the facility undergo an abortion must be licensed as a freestanding outpatient surgical facility. This facility would be exempt from meeting the certificate of need requirements in order to be granted a license.

New York—The senate considered, but did not pass, a bill that would have required a health care practitioner who performs office-based surgery to report at least quarterly any adverse incident (all complications, emergencies, transfers of patients to hospitals as a result of such emergencies, mortalities, and so on) to the Commissioner of Health. Office-based surgery was defined as any operation or other invasive procedure requiring anesthesia, analgesia, or sedation—including cryosurgery, laser surgery, and high-volume liposuction—which is scheduled to result in a patient stay of less than 24 consecutive hours and is performed in a location other than a hospital.

This legislation came about as a result of a report issued in 1999 titled "Problems of Office Surgery." The report, produced by the New York Senate Committee on Investigations, Taxation, and Government Operations, focused on adverse incidents and the physicians who perform surgical procedures outside the scope of their training and experience. Thus, the report presented a bleak picture of the state of office-based surgery in New York, although it did acknowledge that "not every office surgeon is a charlatan."⁷

Virginia—The legislature approved but the governor vetoed legislation that would have required any physician performing surgical procedures in his or her office to report outpatient surgical data to the Board of Health for inclusion in the Virginia Patient Level Data System. These data would have

included principal and secondary diagnosis, external cause of injury, comorbid conditions existing but not treated, procedures and procedure dates, revenue center codes, units and charges, and total charges.


Federal activity

The federal government has not been particularly active in the area of physician office surgery, as the states are responsible for licensing physicians. However, a proposal was developed in August 2000 by the Department of Health and Human Services, Office of Inspector General, to conduct a study on the quality of surgical care through the Medicare program provided in various ambulatory settings: hospital outpatient departments, ambulatory surgical centers, and physician offices.

Outlook for 2001

It is difficult to predict with certainty which states will take up the issue of regulating office-based surgery in 2001. As this issue becomes more familiar to state legislators, there may be greater legislative activity, particularly if a patient experiences a serious injury or death. Further, it is likely that current hot spots, such as Florida and New York, will continue to promulgate legislation and regulations. In addition, areas of the country with traditionally more active legislatures, such as New England and the Pacific Northwest, may see some activity centered on this issue.

ACS guidelines

The ACS Board of Governors' Committee on Ambulatory Surgical Care has developed *Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery*. The third edition of these guidelines was published in May 2000 and is intended to ensure and maintain superior quality of care for the surgical patient who undergoes an outpatient surgical procedure in an office-based or ambulatory surgical facility. Surgeons seeking to order a copy of these guidelines should visit the ACS Web site at <http://www.facs.org/commerce/guidelines.html>. The first copy is provided at no charge. 

issue of office-based surgery and compares a few states' regulation with ACS guidelines. This publication is available on the ACS Web site at http://www.facs.org/about_college/acsdept/hpa_dept/hpa_pubs/pubs.html.

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Author's note: The ACS *Health Policy Brief*, "Office Surgery Regulation: Improving Patient Safety and Quality Care," provides a more detailed discussion of the

Operation Argentina:



BUENOS AIRES

***A surgical partnership
across the Americas***

***by Michael J. Cornwell, MD,
Decatur, GA***



For several years, I had hoped to have the opportunity to live and work in a Latin American country on a temporary basis. My interest originated during my years in school studying the Spanish language and the culture of millions of people not far from our borders.

My hopes began to crystallize after meeting Alberto Ferreres, MD, FACS, at the meeting of the Society of American Gastrointestinal Endoscopic Surgeons (SAGES) in March 1997. Dr. Ferreres completed his training in general surgery and surgical oncology at the University of Buenos Aires School of Medicine, was a 1991 International Guest Scholar of the American College of Surgeons, and had been appointed chair of the department of surgery at Hospital Dr. Carlos A. Bocalandro in Buenos Aires, Argentina, in 1996. Based on my interests, he offered me the opportunity to join his surgical staff temporarily. I then prepared to move out of the country for a year after the completion of my surgical residency training at Emory University in Atlanta, GA, in 1998.

With great anticipation I embarked on my journey, not knowing what lay in store, yet supremely confident that it would be the experience of a lifetime. I was not disappointed.

Despite a solid background in Spanish, it became clear to me that confident fluency would not be attained without full immersion into a Spanish-speaking environment. I achieved this level of fluency through conversation with colleagues and patients. In turn, I opened the door to understanding the Argentine approach to diagnostic management and treatment of surgical diseases. I found that the methods there are in the majority of cases similar to ours; however, slight differences exist that have been met with success.

In addition to the obvious value of further surgical experience in association with several very accomplished surgeons, I was afforded the opportunity to teach medical students and impart knowledge and experience to the residents in training at Hospital Bocalandro. In select cases, I was able to provide valuable guidance and assistance to the staff surgeons, particularly in performing advanced laparoscopic procedures, as a result of my training at Emory under John Hunter, MD,

Overleaf: Dr. Cornwell (left) and Dr. Marcelo Jonquieres completing a laparoscopic cholecystectomy.



Dr. Cornwell (left) and Dr. Ferreres standing in front of Hospital Bocalandro.

Argentina: Statistics

Area: 276,890 km²
 Political subdivisions: 23 provinces
 1 federal district
 Universities: 52

Population: 34,292,742
 Urban: 82%
 Rural: 13.8%

Infant mortality: 29 deaths/1000 live births

Age structure: 0-14 years: 28%
 15-64 years: 62%
 64 years and older: 10%

Life expectancy: Female: 74.97 years
 Male: 68.22 years

FACS. It was a unique privilege to receive such a broad array of exposure, experience, and challenge at this early stage after completing my residency, making the adventure into what will likely be a prominent milestone in my life.

Argentina

Argentina is a fascinating country with a remarkable history. The area covers 1.45 million square miles, approximately one-third the area of the U.S., and is home to 35 million people. Some facts and figures can be seen in the figure on the opposite page.

Before the settlement of the Spaniards in the early 16th century, several native Indian tribes inhabited the land, especially Incas and Guaranies in the north. As the natural resources of the vast land were refined, cities were established and developed along rivers and inland trade routes—including Santiago del Estero, Tucuman, Cordoba, and, of course, Buenos Aires—mainly on the way to Peru as part of the Viceroyship of the Rio de la Plata.

Independence was declared in 1816, and so emerged a period of accelerated growth in agricultural trade, which began in the late 18th century.

During the 19th century, Argentina became a major supplier of foodstuff to Europe, and by the dawn of the 20th century was one of the more prosperous countries in the world. During the early 20th century, the population saw a steady influx of European immigrants.

By 1914, 50 percent of the population was foreign-born, and, in the following 50 years, the immigration rates increased consistently. This ethnic mix is reflected in the present-day population. There are still some people of Native Indian descent in parts of Argentina, but clearly fewer than in other Latin American countries. There is a small population of Asian peoples in the country and even fewer of African descent. So, Argentina is a melting pot of sorts, but of a different mix than we know in the U.S.

The 20th century was a period of ups and downs for the Argentine people and economy due to government instability. The military overthrow of the government in 1930 ushered in a period of military rule that lasted until 1946, when President Juan D. Peron, with the support of his wife Eva

Duarte (Evita), established a “democratic government” with a clear fascist influence. This government, however, was overthrown in 1955, thus inaugurating a period of multiple short-lived governments—all influenced to some degree by the military—until 1983.

Democracy was re-established at that time under the leadership of President Raul Alfonsin, leading to the elections of 1989 when the present President Carlos Menem was elected; he was then re-elected in 1995. A remarkable recovery has taken place in the 1990s as a result of stable government, privatization, and deregulation of previously state-run industries, as well as movement toward opening the economy and markets to international trade.

Buenos Aires

Buenos Aires is the capital city of Argentina, as well as its cultural and population center. There are 3 million people within the city limits and more than 10 million in the greater metropolitan area. Therefore, one-third of the country's population lives in and around Buenos Aires. The city was founded in 1580 and achieved predominance over older cities due to its pivotal location on the wide Rio de la Plata. With ready access to the Atlantic Ocean, it developed into an active center for trade and industry. Its buildings and design reflect the city's European influence. Buenos Aires is a bustling city, dense in its central area, with good infrastructure and effective public transportation.

The hospitals range from small, private facilities called “sanatorios,” which are similar to U.S. ambulatory surgical centers, to medium-sized public hospitals, which care for indigent patients in outlying areas, to large, well-established health care centers, which provide excellent care and function as teaching facilities for medical students and residents. Many of the larger hospitals were started by new immigrants to Argentina.

I found that, at least in the field of surgery, there is a commitment to excellence, striving to keep pace with technological innovations and adding to the international surgical literature. The Argentine Academy of Surgeons meets weekly, and many of the senior surgeons in the city attend. During the meeting, original articles are discussed by their investigators. The majority of surgeons I have come

in contact with have spent time during their training in U.S. hospitals, either for rotations or for extended training. This openness and willingness for interchange is largely responsible for the progressive improvement in the state of surgical care.

The health care system

The primary difficulty in Argentina, as in many underdeveloped countries, is the lack of modern and stable health care programs throughout the country, either due to frequent changes in policies, shortage of public resources, or to the inability and/or lack of interest of the government. However, health care expenditures are fairly substantial, accounting for 8.4 percent of the gross national product, which amounts to approximately \$560 per person annually.

Different health care systems coexist in Argentina:

- The *social security systems*, which is represented by Pami, Argentina's version of Medicare, and state and labor union organizations.

- Private insurance* is represented by the prepaid systems, Argentina's health maintenance organizations (HMOs), and voluntary health insurance programs. Prepaid systems in Argentina have developed in the last five years into organizations that closely resemble our HMOs, their main interests being cost-containment and their own profit. Capitation and managed care have been a constant.

- The *public sector* provides service through hospitals and assistance units. The hospitals have contended with very low budgets, heavy delays, and corruption. All of the population is entitled to ben-

efits, although the majority of the patients are low-income workers and the unemployed.

Health care is delivered through different types of hospitals:

- Public hospitals* have scarce resources and they rely on the special efforts of some workers and



The magnificent waterfalls and rainforests of Iguazu, at the northern border of Argentina with Brazil.



The front of Hospital Dr. Carlos A. Bocalandro, in the Zona San Martin in the northern suburbs of Buenos Aires.

health-care providers. Many of them have serious inefficiencies. Academic surgery and training programs are the exclusive domain of public hospitals; however, attending physicians work there only during the morning hours.

- *Social security hospitals* have closed systems, which operate with the contributions from employers, employees, and funds assigned for them by special legislation. They are administered by the same people who finance them; therefore, political and labor union influences often affect them.

- *Private hospitals* belong to either foreign or religious communities or to physicians' groups or non-medical organizations. In recent years some of them have been purchased by the prepaid systems. With access to private funds, many of these hospitals are able to equip themselves with more advanced and expensive medical devices and machinery.

Admission to public medical schools is unrestricted and absolutely free. As a result of few requirements for entry, more physicians than necessary graduate. Argentina has one of the highest ratios of physicians per capita (1/220). Nonetheless, there are graduates of the University of Buenos Aires who have been distinguished with the Nobel Prize: Bernardo Houssay, Federico Leloir, and Cesar Milstein, presently living in the U.K. Some private schools of medicine have opened in recent years; some are very good and others are below standard.

To become a surgeon, the medical graduate must undergo further training; although under present law he or she is technically allowed to practice in a field of interest without further training, due to the lack of postgraduate regulations. Surgical training faces difficulties because residency programs (98% in public hospitals) accept only 22 percent of candidates, and the low salaries usually demand help from family members.

Hospital Bocalandro: In a day's work

Dr. Carlos A. Bocalandro was a physician who, in his 40s, changed his interest in pulmonary diseases to an interest in public health. He was Minister of Health of the Province of Buenos Aires from 1945 to 1952 under the presidency of Juan D. Peron, returning to the same post in

1973, during Peron's third term. He died while still in office in 1974.

The hospital that bears his name, which is where I was based, is located in the suburban area north of Buenos Aires, near easily accessible highways. The hospital opened in 1996, and, in the previous months, Dr. Ferreres was asked to organize the department of surgery and then was appointed chair. It is a 180-bed facility built in two flats, and its administration is appointed by the Director General of Hospitals, which office is based within the Health Ministry of the Province of Buenos Aires.

Given that the lack of resources is a constant strain on the public hospital, the means that were available in the surgery department at Hospital Bocalandro were remarkable. This was in great part due to the effort of Dr. Ferreres and his team, in addition to the backing of a nonprofit foundation, Fundacir (Fundacion para el Desarrollo y Avance de la Cirugia), which Dr. Ferreres established himself. Fundacir was organized with the aims of obtaining resources for the daily work at the hospital, helping the poor population with their medical care, supporting clinical research at the department, and developing public awareness in surgical topics.

Despite its youth, Hospital Bocalandro has made great strides toward becoming a solid health care facility with the organization and focus needed to make itself an effective teaching institution. In the department of surgery, which encompasses vascular, thoracic, and general surgery, operations are scheduled on Monday, Wednesday, Friday, and some Saturdays. Formal morning rounds start at 7 am, and first cases are scheduled for 8 am, although they rarely start on time. There are five operating rooms (quirofanos) within the surgical suite.

Laparoscopic cholecystectomy is by far the most common operation, as gallbladder disease appears to be even more endemic in Argentina than in the U.S. Other common elective operations include: hernia repairs (both inguinal and ventral); colon resections; soft tissue excisions; vein stripping; and thoracoscopic drainage or pleural debridement for empyema, advanced stage pneumonia, or tuberculosis. Arterial bypass procedures, thyroid surgery, and esophageal resections are performed occasionally. A harmonic scalpel is on hand in the operating suite for the occasional laparoscopic Nissen

fundoplication or splenectomy. Noticeably absent is breast cancer surgery, as this condition is addressed by the gynecologists at Bocalandro and throughout most of Argentina.

The elective procedures are generally completed in the morning and early afternoon hours, while the urgent operations tend to gather in the late afternoon and evening. Cholecystectomies, appendectomies, abdominal exploration for bowel obstruction, and trauma surgery are the most common urgent procedures. The majority of trauma surgery involves stab and gunshot wounds, which arise in the surrounding population, many of whom live in “villa miseria” (misery villas)—a collection of small shacks and makeshift houses linked together in close proximity.

With regard to regional pathology, especially zoonosis and parasitosis, the climate, environmental factors, and also the degree of poverty in the population contribute to the specific diseases found in a given region or country. For example, in Argentina there are 1.5 million people infected by *Trypanosoma cruzi*, who may eventually go on to develop Chagas’ disease affecting the digestive tract and the heart. The vector is an insect known as vinchuca. In the northeastern areas Chagas’ disease is responsible for megacolon and dilatation of the esophagus. Hydatid disease, parasitic infection produced by *Echinococcus granulosus*, is also an endemic disease in the region of the Pampas and Patagonia, where big cattle ranches are located. This disease is responsible for a large percentage of the thoracic and liver sur-

gery performed in the country, due to the cysts resulting from the infection. HIV has been an issue in the surgical community, due to risky sexual behavior and the abuse of IV drugs. In many institutions patients are tested routinely for HIV and



Drs. Carlos Colombres (left) and Miguel Caracoche honing laparoscopic skills on a practice simulator.



Dr. Ferreres at work performing laparoscopic surgery.

hepatitis as part of the preoperative evaluation.

Conferences are held on Tuesday and Thursday mornings, at which time some of the more complex and interesting cases are presented and discussed. These conferences are intended for teaching purposes as well as for decision making within the department. A Saturday morning meeting is used to discuss the business and ongoing projects of the department. There are no specific weekly morbidity and mortality conferences, although complications are discussed in the last Saturday morning meeting of each month and occasionally during the weekday conferences.

Lectures covering a broad curriculum are given to the medical students two or three days per week by surgeons in the department. The students also follow specific patients and go to the operating room to observe procedures. An exam is prepared and administered to the students at the hospital at the end of each three-month rotation period.

Data from operative cases are catalogued very systematically, in that every operation is filed in a computer spreadsheet. Several other surgical diseases that are the subject of ongoing research are subcategorized into other, more focused computer files. This organization makes for more easily retrievable information for compilation and analysis when putting together investigative reports. Members of the surgical staff are frequent participants at surgical meetings in both Argentina and the U.S., where projects are submitted for presentation and/or publication. With the schedule, activities, and responsibilities undertaken by members of the surgical staff, there is a sense of drive and energy within the department, particularly encouraged by Dr. Ferreres' leadership.

During my stay, the telephone company provided a donation of four dedicated high capacity lines, so that hands could be put to work in an ambitious project of telemedicine with local and foreign institutions, mainly from the U.S.

Surgeons on staff at Bocalandro take call in-house for one 24-hour period per week and are paired together to be on duty the same day every week. One or two of the residents will stay on-call any given night. All of the staff surgeons have practices at other hospitals in the city, as the pay at Bocalandro is insufficient to make a living. This practice may involve taking care of private patients at other hospitals or clinics, staff appointments at

other hospitals, or simply taking on-call duties at other facilities.

My duties and role at the hospital were flexible and evolving. I worked in association with any one of the staff surgeons in both the operating room and clinics, as I was not technically on staff. In short, I took part in all the activities of the department. This included participating in patient rounds and conferences during which, on occasion, my thoughts or opinions were elicited regarding a particular case. I partnered or assisted with one of the other surgeons in performing a wide range of operative procedures. I held discussions with groups of first-year medical students regarding the U.S. system of medical education and training and our health care delivery system. Further, I had the rewarding and challenging experience of preparing and presenting lectures on breast disease, thyroid disease, and melanoma in Spanish to the sixth-year medical students on rotation at the hospital. I was relieved to hear all of my students passed their final exams in surgery.

The department of surgery organized an informal laparoscopic skills course for the benefit of its own staff and residents. Several stations were created with models and simulations to improve laparoscopic skills. For this course, I gave instruction in intracorporeal knot-tying. Fortunately, a laparoscopic Nissen fundoplication was scheduled that day, so the skills could be put to use readily.

With regard to ongoing studies, I assisted in the production of videos, abstracts, and poster presentations, especially those submitted for meetings in the U.S. (SAGES Scientific Congress Session and Society for the Surgery of the Alimentary Tract Digestive Disease Week). In sum, all of the activities were broadening and rewarding to me and supported the efforts of the department of surgery.

Value in partnership

It has become increasingly clear over the last decade that global boundaries and barriers are melting away in a number of industries. The bonds between countries grow ever stronger, yet ever more transparent with regard to multinational companies and the financial markets. The medical profession has lagged behind in actively initiating interchange across borders. Certainly communication of medical developments and innova-


tions take place at conferences and through the international literature. However, it is a different experience altogether to step into another medical arena and witness and experience how other countries deliver health care to their populations. Many countries are undergoing a similar evolution to the one in the U.S. with regard to the systems used to pay for health care. There is much that can be learned and conveyed as we work through what works and what does not work.

It is also instructive to witness first-hand the way in which a country educates and trains its doctors. As we gain a greater understanding of this process, it becomes easier to conceptualize what is occurring at the level of the patient-doctor relationship and how health care is actually being delivered. We will find that each country has its unique set of diseases that occupy a great deal of effort and resources. In the process of this discovery we may uncover clues or confirmation of the origin of certain diseases and, therefore, facilitate finding cures, vaccines, or better treatments. Moreover, better methods of preventing the occurrence of certain diseases may be brought to light, thereby encouraging changes to the public health approach.

We need to think of ways to encourage and support organized participation on the part of doctors in the U.S. in this form of interchange and partnership. At present, there are very few programs that facilitate the process for doctors while in training and fewer still for those in practice. The experience of traveling abroad would be worthwhile, indeed, for a medical student or resident, but it would be much more rewarding for a doctor who has completed his training because of the many opportunities it opens up.

It would seem that teaching institutions and universities would be the logical place to look to initiate an organized system for physician exchange. However, it is also clear that these institutions are under increasing financial pressure as competition for the health care dollar grows in intensity. Therefore, funding for such programs may need to come from other sources, such as charitable organizations, corporate sponsors, and not-for-profit organizations. Physician organizations and government agencies such as the Centers for Disease Control and Prevention, Peace Corps, and National Institutes of Health should be involved in encouraging and supporting such programs. The World

Health Organization and the World Bank should see benefit in lending support for the improvement of global health.

The first challenge will be to voice a convincing argument for the need of such programs. For this task, physicians and their organizations are best equipped. 

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A reminiscence:

Serendipity steers surgeon to discovery

by

**James C. Neely, MD, FACS,
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“The pioneers, the first who struggle out of the established systems and who form new and useful conceptions, appear only half right, incomplete; and their names stay remote. But they are perhaps more to be cherished than those who come after, who clear off the debris and offer a neater, more full-blown view.”

—Jacques Barzun, *From Dawn to Decadence*

The Golden Age of Surgery

In 1955, at age 28, I was a second-year surgical resident at Cincinnati General Hospital aspiring to be an academic surgeon, receiving room and board for services and a check for \$5.26 every two weeks. The money, they said, was for coffee and cigarettes. The room and board, they said, was to keep us near and attentive to our patients at all times with as little distraction as possible. We worked all day and two nights out of three in the hospital. It was our life.

It was what some might call the “Golden Age of Surgery,” learning at the feet of great surgical giants, such as Zollinger, DeBakey, Ravdin, Heuer, Cutler, Welsh, Churchill, and Altemeier. It was a time for the big operation for the small cancer and bigger operations for the big cancer. It was a time for radical neck dissections, radical mastectomies, hemi-pelvectomies, four-quadrant arm and leg amputations, huge aneurysms, and removal of 80 percent of your stomach if you had intractable duodenal ulcer symptoms like I did. The professor repeatedly told us how lucky we select few were to be learning this great craft, but if we wanted to be university surgeons like him, we had better make some original contribution to medicine during our residencies.

Most of us were veterans of two recent wars, World War II and Korea. Many of us still plied the hallways in our khaki pants or Marine brown shirts under our white coats, worn as much as a badge of pride as a wardrobe convenience. There was a macho quality about the hierarchy that we naturally honored and a mock insouciance for the anguish and travail we quietly endured together. The service had prepared us well for this environment. Complaint was taboo, discipline was re-

spected, and stress was internalized without complaint.

In those days, internalized stress was considered the major cause of routine peptic ulcers, and, in my case, there was no need to invoke any other reason for the symptomatic ulcer deformity I had developed in my duodenum. Keeping with the program, I suffered in quiet distress and discomfort, gobbling milk and antacids through 10-hour operations, often dead on my feet with fatigue and pain, always hoping I could survive without bleeding again until summer rolled around and I could have a restful vacation.

The professor, in his infinite wisdom from the Heights of Parnassus, had decreed that each resident should take a month off every summer. With a little imaginative trading off and interpolating weekends and holidays, you could parlay this into five or six weeks away, mercifully time enough to heal your wounds.

Introspecting over my affliction and my high ivy university life, I came to feel I might be aspiring to levels in medicine I was not emotionally suited to pursue. As a result, and much to the distress of my family and girlfriends of the moment, I decided to spend my vacation that year working as a general practitioner in some bucolic paradise where there were restful, languorous days. I would read the poems of W.B. Yeats, ruminate on ultimate values, and help people by making them simply feel better about themselves and their lives.

Rural revelations

I wrote to 20 state medical societies that seemed geographically appropriate to my aspirations and, to make a long story short, had to choose between West Virginia and Maine. I ended up taking a locum

tenens in Kesar Falls, ME, a small mill town 60 rocky miles west of Portland in the foothills of the White Mountains near the New Hampshire border. I was to fill in for Paul Marston, MD, the local physician who hadn't had a vacation in 40 years.

The other decree from the professor was that his residents find a permanent and progressive sense of serendipity as they progressed through the formative years of surgical training. With all the opportunity for patient care, he emphasized that the fresh associations that burst forth from youthful minds could create new and original ideas. It was a bonanza just waiting to be harvested by fertile young minds. It was present every day before you, "a movable feast," he said, one you should take with you on your holiday when you would have time to reflect on original ideas. Thus was serendipity, the gift of finding valuable or agreeable things not actively sought: Einstein watching moving trains and hitting on the idea of relativity, Darwin in the Galapagos thinking up the theory of evolution while observing the flights of finches, Fleming accidentally noting the effects of penicillin mold on a dish of bacteria. In the vineyard of research it is always hoped one will experience a moment of epiphany that will ultimately lead to a contribution for the betterment of mankind. Serendipity was the only thing I took with me from the university for my vacation in Kesar Falls.

I had no problems connecting with Dr. Marston at the Portland Airport. I couldn't miss him. He was a big bull of a man with a barrel chest, a protuberant abdomen, and a broad infectious smile. He was an extreme extrovert, the kind that finishes your sentences for you.

That afternoon, before going home, he took me on rounds to orient me to his patients. We drove the first of what turned out to be 10,000 miles of driving for me in six weeks of making house calls on the halt and lame, the dead and dying, the infirm and mentally ill, the goldbricks and compulsive eaters, and all manner of sights, sounds, and smells of human pathology, both soluble and insoluble, appreciative and hostile. Mostly Dr. Marston told me, "When in doubt, give them a shot of B-12. Tell them it's the latest and greatest." I knew B-12 had been found curative in pernicious anemia, especially in old people whose stomachs no longer secreted acid, but it seemed a little dis-

honest to give it out routinely as a placebo. By the time I had reached 3,000 miles in my driving, however, I was giving B-12 shots to everybody, and they loved me for it.

As I think back on my time in Kesar Falls, cases pile in upon my memory attached to real faces and real people as if it were yesterday. I remember the in-home delivery of a baby of a multiparous woman who knew more about unraveling a strangulating umbilical cord from her newborn baby's neck than I did. I remember an angry, old, intoxicated employee who sat on the end of a logging chute in protest against his employer who warned him once to move, then sent a log crashing down that broke his back and eventually killed him. I remember caring for a woman the whole time I was there who had been operated on for a simple breast biopsy at the Massachusetts General Hospital by one of the country's finest breast specialists, who had caused her wound to form a huge blood clot and a smoldering, disfiguring infection. I remember the excitement one night of correcting congestive heart failure with the old-fashioned technique of rotating arm and leg tourniquets because I was out of medication, of reversing childhood asthma attacks with intravenous aminophyllin, and of removing splinters from toes and cinders from eyes at all hours of night and day.

I write of these memories not to distract, but to show how, with all my real doctoring going on, serendipity was, nevertheless, gradually making its mysterious inroads into my healing ulcer. It had come about just as the professor had said it would: from seeing and talking with a patient, W.D., who had come into my office two weeks after my arrival complaining of a persistent ulcer-like stomachache and a lump in her neck. Feeling the lump, it seemed high to me, high and on the right, a 2 cm mass separated from the thyroid, possibly an enlarged parathyroid gland. Getting to know her, talking with her over a period of two or more weeks, the truth finally came out. She had been to Boston and seen the great endocrinologist Fuller Albright, MD, who had done some tests, told her that her serum calcium was elevated, made the diagnosis of parathyroid adenoma, and recommended curative surgery, which she had refused.

In the early 1950s, Albright had beautifully delineated the function of the neck's parathyroid glands, showing how they regulated calcium me-

tabolism in our body by maintaining a factored chemical metabolism with phosphorous in our bloodstream. The normal absorption of calcium was through our intestine and only from our bones whenever the body was not getting enough for proper balance with circulating phosphorous. When there was a functioning tumor, however, such as W.D. had described with her parathyroid adenoma, there was a massive outpouring of hormone that caused calcium to be removed from bone and to circulate at toxic levels in the body.

The mnemonic drilled into us for such parathyroid adenomas was that they caused “stones, bones, and abdominal groans.” The stones were kidney stones resulting from the precipitation of calcium salts secreted in superabundance in the urinary system, usually small but sometimes growing to staghorn size, and always painful. The bone symptoms came from calcium demineralization in the skeleton, from weakness in support, causing pain on motion and often stress and spontaneous fractures. If hypercalcemia caused the stone symptoms and hypercalcemia caused the bone symptoms, it seemed to follow as the night the day that hypercalcemia also caused the abdominal groans. But, we are all products of our time, and that was not the way the medical wind was blowing then. When I left Kesar Falls, I had persuaded W.D. to have her operation and myself that parathyroid hormone itself was causing ulcers.

Beliefs about ulcers

“Kein geschwur ohne sauer.” Translated from the German, it means “no ulcer without acid.” It was our mantra. The work of Lester Dragsted at the University of Chicago had sensitized all of us to the powerful effects of gastric hydrochloric acid. If you took a beaker of gastric juice and put it on the mantle, he claimed, you could add any protoplasm in the world to it and see its ability to digest all living tissue. That’s what it is doing with the stomach when ulcers form. It’s astounding we can control it at all, that it doesn’t digest away our insides.

Taking Dragsted’s lead, all efforts were directed at acid control, including 80 percent surgical resections of the stomach, which removed nearly all the acid-producing cells, the parietal cells, at the extreme top of the stomach. All efforts short of

surgery were being directed to control the production of acid by finding the source of its stimulus. Rather than block the acid, we looked for the cause of its secretion. There were no *H. pylori* bacteria to implicate and no H₂ acid blockers like we have today, virtually eliminating the acid component of routine ulcer disease. We looked to the cause of acid release. We looked to emotions and hormones.

In the 1950s, the medical world was in awe of psychiatry and endocrinology. Psychiatry was the only course we were required to take every term for four years at Columbia University’s College of Physicians and Surgeons. Psychiatry’s handmaiden was endocrinology. Together they described the hypothalamic-pituitary-adrenal axis, which involved the seat of our emotions in the brain neatly influencing the body’s hormonal response to stress. A state of fear or anxiety was relayed to the pituitary master gland, which signaled the adrenals to produce adrenalin, which got your heart racing and your stomach churning as excitatory impulses releasing acid were also delivered from the brain to the stomach via the vagus nerve.

About that same time, the surgical world was electrified by a report from Zollinger and Ellison at Ohio State indicating they had found a state of hyperacidity in a small series of patients in whom ectopic tumors of the bowel were found at a distance from the stomach that actually produced a powerful circulating hormone, gastrin, which had been known for years to act on the parietal cells of the stomach, causing release of acid in large amounts. Gastrin had been discovered in the lining of normal hog stomachs 30 years earlier with little fanfare. But suddenly, with the knowledge that Zollinger’s patients had been afflicted with gastrin toxicity, all developing large recurrent ulcers in the stomach and small bowel, associated with massive diarrhea, the thrust of research on ulcer formation was once again intensely refocused on the endocrinological basis of ulcer disease. Three stages of stomach digestion were delineated (cephalic, gastric, and intestinal), all of which were carefully described as having a hormonal basis that became dysfunctional in ulcer disease.

In this atmosphere, it was a very small step to think that parathormone could profitably join the parade of hormone experiments to delineate a cause of ulcer disease, as it had already been implicated by virtue of so many ulcers being found in

patients with parathyroid tumors. So, research was rapidly conceived to demonstrate the influence of this hormone on gastric secretion. These experiments were mostly of an acute nature because any prolonged administration of the parathyroid hormone gave rise to a severe immune reaction, meaning there was never an experiment successfully sustained long enough to produce a state of hypercalcemia analogous to humans. Not surprisingly, no changes in acid secretion ever were observed.

A ride in the woods

A few years after my summer in Maine, I was “back in the bullpen” and feeling better, as I had attained the security of seniority, despite the stressful pyramidal nature of a training program that began with eight residents and finished with only four chief surgical residents. I once again thought to take a restful summer vacation prior to beginning my chief residency in surgery at Cincinnati General Hospital. I was offered and accepted a job as staff physician at a dude ranch in Wyoming. In the years since Kesar Falls, I had followed with lingering interest the research literature on the formation of peptic ulcers in cases of parathyroid disease. The focus had remained on parathormone and little progress had been made. One thing I had noticed rather casually in some of my clinical patients was that conditions that released calcium by destroying bone, such as tuberculosis, sarcoidosis, and metastatic prostate and breast cancer, were often accompanied by severe, recalcitrant, symptomatic stomach ulcers. But I didn’t really think about it much until Wyoming.

There are not many places in this world more beautiful than the eastern foothills of the Little Big Horn Mountains in June. At the HF Bar Ranch there was a plethora of children, young girls and boys whose youthful parents were more than happy to unload their care on the reliable young surgeon. I would arrange horseback expeditions for them to explore this enchanted area. One day, on a high noon ride, two children sprang ahead to follow a deer that led us through a ravine to a trail that opened suddenly onto a deep pit wedged between four large rocks. There before us, piled high as the eye could see, was a mass grave—the broken and scattered skeletons of hundreds of deer. With the noon sun overhead, we were able to see the

eburnated bones with shining clarity. It was our own secret Stonehenge. The children wanted to gather the bones immediately. I said they had to promise to keep our secret. My idea was to assemble a deer skeleton in my cabin and teach some anatomy. So, every day for a month we returned and puzzled them together to form a fine deer skeleton.

I tell this tale to illustrate how serendipity was working its slow, subtle wiles on me in ways that would eventually lead to my one good research idea. Traipsing back and forth on horseback with bones hanging from saddles and rattling in the wind like some ghoulish mobiles, I got to thinking about calcium metabolism once again. I went over in my mind the whole scenario of how people with parathyroid adenomas had peptic ulcers, how parathormone itself could not be demonstrated to cause hypersecretion of gastric juice, that gastric juice was the sine qua non of ulcer formation, that parathyroid disease patients had elevated blood calcium levels, that other patients with elevated calcium levels also got ulcers. Suddenly it came to me that hypercalcemia itself caused gastric hypersecretion and ulcers followed in kind.

Such was my rare moment of epiphany, a brief clear vision after seven long years of muddled thinking. It had happened just as the professor said it would. I felt as Constantine must have felt when he saw the sparkling vision of the cross at the bridge. With the children riding nearby singing, I rode home in perfect peace, watching the sun spread its magnificent colors and sink slowly behind the Big Horns. Stealthy serendipity had done its job.

But I only had my idea. Now I had to prove it.

“Strong” to the rescue

The next year, by extreme good fortune, I received a research fellowship at the University of California in San Francisco and a munificent award of \$10,000. My idea was to set up a group of dogs similar to those Dragsted was using and the kind Pavlov had used, with pouches that would allow me to measure acid secretion. I established a colony of 25 dogs, all healthy, each with a little pouch hanging off the side. They were fed a consistent diet at the same time each day, and the pouches were measured for content and volume


each morning. After a baseline stabilization period of three months, the dogs were rendered hypercalcemic by intramuscular shots of vitamin D. Serum calcium levels were measured regularly, and when they became elevated, the vitamin D was discontinued and the blood calcium level allowed to coast back to normal over time. It was a neat project.

My experiment was going great guns for a year-and-a-half, when a researcher's worst nightmare happened. The dogs became stricken with distemper. Sometimes I stayed up all night with them to nurse them back to health, but to no avail. I was sick, heartbroken. I watched them go. There was absolutely nothing I could do. One by one all of them died...all but one precious dog, a boxer we called Strong because of the special pungency of his urine. You and I and the world owe Strong a debt of gratitude, for while he watched his friends die and leave him all alone, he survived, allowing me to complete my experiment.

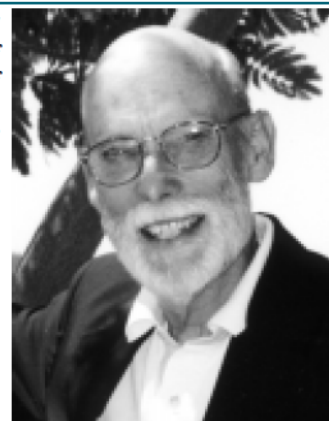
Mine was a chronic experiment intended to simulate the human hypercalcemic state by extending it over many months at a time. Strong, therefore, provided us with his own control, exhibiting before, during, and after phases of blood calcium alterations. I was able to show that when his blood calcium level rose, his gastric output of acid increased, and when those elevated levels gradually returned to normal, so did his pouch secretion. With Strong's help, I proved my thesis: hypercalcemia causes chronic gastric hypersecretion, which can cause ulcers. In retrospect, it all seems so simple.

When I excitedly took my results to the chair of the department, he immediately removed from the paper all the names of the colleagues who had so diligently helped me, and said it didn't have a chance for publication because, after all, it was just one lousy dog. But, he said I could send it anywhere under my name alone and without his imprimatur. So I did. I sent it to our most prestigious surgical journal, *The Annals of Surgery*. Miraculously, I received a special delivery acceptance by return mail. Now that it had been accepted, the chairman, without apology, saw fit to add his name to the paper. But, by then, I didn't care because also in the acceptance was a promise for immediate publication due to the importance of the finding. It came forth in volume 155, pages 406-411, 1962, of the *Annals*. My reaction was the time-honored one

of authors, who tell you, yes, it's nice to see it out there, but it was so much more fun doing it.

W.D. had her operation and was cured, Marston continued to give B-12 shots for 25 more years, and although more and bigger studies on hypercalcemia were conducted to prove its exacerbating effect on gastric secretion, Strong's effort was the breakthrough, the seminal pilot study that inspired others to go on to greater heights and international recognition. For my part, I quietly entered the private practice of surgery, far away from people who added and subtracted names to papers. Before leaving, I undid Strong's pouch, hooked him up proper, and kept him as my honored pet, encouraging him to father as many pups as he wanted until his natural death many years later. As I think back on it now in the twilight of my career, it seems time the world heard of Strong and me and of the sunlight just right on the deer bones in their secret hiding place one summer high noon long ago in Wyoming, when an idea came clean to me and finally was born. 

Dr. Neely is a retired clinical professor of surgery, University of San Francisco, CA. He is a published author and poet.



Statement in support of motorcycle helmet laws

The following statement in support of motorcycle helmet laws was developed by the Subcommittee on Injury Prevention and Control of the Committee on Trauma of the American College of Surgeons. It was approved by the College's Board of Regents at its October 2000 meeting.

Total care of the trauma patient includes endorsement of measures designed to prevent injuries. Regarding the use of motorcycle helmets, the American College of Surgeons recognizes that:

- Helmeted motorcycle riders have up to an 85 percent reduced incidence of severe, serious, and critical brain injuries compared with unhelmeted riders.
- Unhelmeted motorcyclists are over three times as likely to suffer a brain injury when compared with helmeted motorcyclists.
- The average inpatient care costs for motorcyclists who sustain a brain injury are more than twice the costs incurred by hospitalized motorcyclists without brain injury.
- A large portion of the economic burden of motorcycle crashes is borne by the public.
- In states with universal helmet use laws, helmet use is close to 100 percent.
- When universal helmet use laws are enacted, helmet use increases and fatalities and serious injuries decrease.
- When universal helmet use laws are repealed, helmet use decreases and injuries and associated costs increase.

Therefore, the American College of Surgeons supports efforts to enact and sustain universal helmet laws for motorcycle riders.

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One man's mission against cancer

by ERNIE BODAI, MD, FACS, *Sacramento, CA*

How it all started

I will never forget that night. The idea came to me in a flash. In December 1995 I was stamping holiday cards and preparing for a lecture on the history of breast cancer surgery, when suddenly it occurred to me: Why not have a stamp to raise money for breast cancer research? The next thing I knew, I had become a cancer activist.

I have taken care of almost 3,000 women with breast cancer, and I have seen every day how this dreadful disease affects them and their husbands, families, and children. The devastation of the disease wore on me every day. I decided I could treat these women for the rest of my life, or I could help eradicate the disease. I chose to act—immediately.

I first contacted the U.S. Postmaster General with the idea for the stamp and was promptly turned down. Then I wrote letters to all the female members of Congress, with no response. Incensed, I flew to Washington, DC, and started knocking on the doors of Capitol Hill lawmakers. I essentially became a full-time lobbyist while continuing a full-time breast surgical practice. It was exhausting, but I firmly believed that my efforts and hard work would pay off. Americans are very philanthropic, so I knew that all I had to do was to get legislation passed and the money would start being raised. Not an easy task, as I was soon to learn.

After two long years and a dozen trips back and forth across the country, my persistence paid off in 1997. Introduced into

the U.S. Senate by Sen. Dianne Feinstein (D-CA), the Stamp Out Breast Cancer Act authorized the Postal Service to establish and sell this special stamp—known as a semipostal—for two years to raise money for breast cancer research. The stamp became the first in the nation's history dedicated to raising funds for a special cause and has become the second highest selling stamp in postal service history.

The legislation was reauthorized and signed into law by President Clinton in July 2000 for an additional two years. This action will allow the program to again allow a surcharge of up to 25 percent above the value of a first-class stamp (the stamps sell for 40 cents), with the surplus revenues going to breast cancer research. The measure also includes a provision preventing the deduction of money raised from the sale of the stamps from other federal funds that a research institute receives. To date, more than \$20 million has been raised for breast cancer research from the sale of the stamps.

Still more to accomplish

In 1998, I founded a not-for-profit organization—Cure Breast Cancer, Inc.—to promote the stamp and to continue to raise money for breast cancer research. Each year in California, more than 1,000 women and men who cannot afford treatment are diagnosed with breast cancer. Early detection of breast cancer is the best protection. However, there is no benefit of early detection if adequate treatment cannot be obtained.

Last October, President Clinton signed the Breast and Cervical Cancer Prevention and Treatment Act of 2000. This law will provide treatment for low-income women who have been diagnosed with breast or cervical cancer. The measure will allow states to expand their Medicaid programs to cover costs by providing states with federal matching funds at no less than 65 percent.

In addition to the action taken in Washington, DC., a measure was passed by the California legislature on October 15, 2000, to create a breast cancer license plate to raise money for uninsured and underinsured women who need treatment. The Breast Cancer Treatment License Plate will be issued by the Department of Motor Vehicles (DMV) for vehicles registered in the state of California. The plate features the image of the Pink

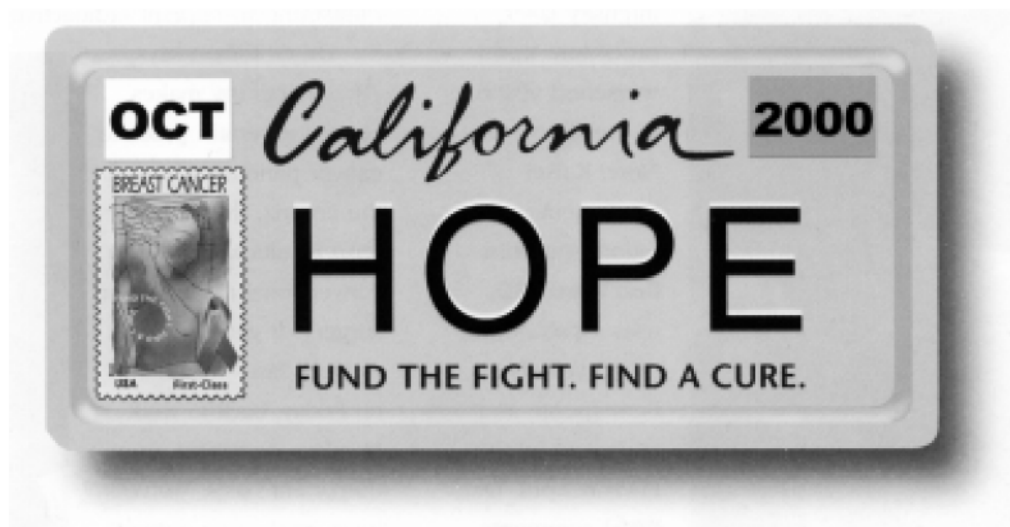


The stamp depicts Diana, the huntress and goddess of fertility, reaching behind her head to pull an arrow from her quiver to fend off an enemy, in this case, breast cancer. The image reflects the same position that a woman assumes for a breast self-exam and mammography.

Ribbon and the Breast Cancer Research Postal Stamp. Together they symbolize hope for treatment and a cure. The plates cost \$50, with \$34 going into the treatment fund. Fees are tax-deductible. After the DMV's administrative costs are met, a small percentage will go toward the California Environmental License Plate Fund (for personalized plates), and the majority will go to the Breast Cancer Treatment Fund. Funds will be distributed through grants to health care providers offering treatment to uninsured and underinsured patients. Cure Breast Cancer, Inc., must collect 7,500 paid applications by December 31, 2001, before the DMV will authorize the production of the plates.

A new fight

In June of last year, I was diagnosed with prostate cancer. But as most people who know me understood, this would not set me back. Instead, I'm using my diagnosis to encourage men and women to have regular cancer screenings. My job is to save



The prototype breast cancer license plate.

lives, and I believe that taking this experience and sharing it with others will save lives.

While breast cancer has emerged from the shadows, prostate cancer remains more shrouded—despite the fact an estimated 180,000 new prostate cancer cases will be diagnosed this year and nearly 32,000 men will die of the disease, according to the American Cancer Society. The numbers, particularly of new cases, closely mirror those for breast cancer.

So my new message is this: *"Screen Together—Live Together."* I have started a national campaign for women to take their husbands and boyfriends to get screened for prostate cancer when they go for their annual mammograms. Early detection is crucial for surviving both diseases.

I was very excited to hear that last October the Prostate Cancer Research and Protection Act was signed by President Clinton. This legislation will expand the Centers for Disease Control and Prevention's authority to provide grants to state and local health departments to conduct screening programs to detect prostate cancer.

In August of 2000 I underwent brachytherapy (seed implantation) for my cancer. I would like to take this opportunity to say how grateful I am to

my physicians and the community for their unwavering help and support.

I never use the term "cancer survivor." That implies that once you're healed, the fight is over. But cancer affects your life so deeply, it's never over. It won't be over until the day that not one person gets cancer ever again. Q

Dr. Bodai is director of breast surgical services, Kaiser Permanente Medical Center, Sacramento, CA. For more information, visit Dr. Bodai's Web site at <http://www.curebreastcancer.org>.



Socioeconomic tips of the month

Planning for retirement

At the recent Clinical Congress in Chicago, Fellows, Initiates, Candidates, and others had an opportunity to get one-on-one practice management tips through a consulting service sponsored by the Health Policy and Advocacy Department. The requests for information had a dominant theme—transition in practice. Tom Loughrey, CEO of Economedix and a practice management consultant for the College, had the following suggestions for surgeons considering retirement. Last month, Mr. Loughrey provided recommendations for surgeons who were thinking about adding new associates to their practices.

Q. What are my obligations when I retire?

A. Surgeons planning to retire must deal with several ethical and legal considerations. First is the issue of continued patient care. There is an ethical and, perhaps, a legal obligation to make certain patients are given sufficient time to select another surgeon. This is usually done by formally notifying patients by mail and referring the patient to either another physician or a resource, such as a county medical society, that can assist in the search process.

The retirement process is simplified if the surgeon is in a group practice that will pick up all the patients, their records, the employees, and the space and equipment. In a solo practice, though, all of these issues must be handled independently. The following information may be used as a checklist for the retiring surgeon who does not have a group to pick up the practice assets.

Patient medical records and charts

Surgical practices must maintain patient records and have them available to patients and physicians who may need them. This could mean storing them for many years. It would not be unusual for a retiring general surgeon to have more than 10,000 charts that need to be stored and accessed. There may be related photocopying costs as well.

Maintenance of these charts can be expensive.

If stored commercially, the cost may be approximately \$2 per standard carton. If a carton holds 200 charts, a retiring surgeon with 10,000 charts needs to keep 50 cartons in storage at a monthly cost of \$100. Most commercial record storage companies will charge each time a carton must be pulled and a record extracted or returned. This charge will vary, but \$5 or more per pull is typical. A retired surgeon with 50 stored cartons and 10 chart retrievals each month will have a total monthly chart storage bill of \$200 plus charges for photocopying, mailing, or delivering.

Of course, these charges can be avoided if someone else takes over the charts for a retiring surgeon. Simply by getting another surgeon to take custody of these charts, a retiring surgeon could avoid as much as \$10,000 or more in costs in the first five years of retirement plus the associated work and responsibility for the charts.

Personnel

Staff will need to be notified in sufficient time to allow them to find new positions. The retiring physician, though, should be careful not to make his or her plans known so far in advance that prolonged understaffing could become a problem. Usually one month's notice or pay in lieu of notice is acceptable.

Prior to retirement, you should check to see if there are any contractual liabilities or obligations related to staff. If there has been a retirement plan in place and it is going to be discontinued, there are requirements for notifying employees. Check with the retirement plan administrators to find out what will have to be done to shut down the plan. It normally only requires a timely notice to the employees so they may transfer assets to other qualified retirement plan accounts.

At the time the practice closes, employees with accrued vacation time will need to be paid for that time under most state laws. Also, most employees will be permitted to file for unemployment benefits if they do not find other work right away. Unemployment benefits paid to former employees generally should not have any financial effect on the retiring physician.

Facilities and equipment

Most surgeons rent their office space. If their leases expire at about the same time as they retire, there shouldn't be any problems. However, if a lease expires significantly before or after the retirement date, there could be some financial liability.

If a normal lease extension is five years, but you plan to retire in three years, it's better to sign a three-year lease even if it requires higher monthly payments. Otherwise, you will have to either find someone to sublet the space or continue to pay rent on an office you do not need. If you plan to retire within one year of the lease ending, it may be best to rent on a month-to-month basis. This arrangement could prove problematic, though, if the landlord gets another tenant and cancels the lease before the retirement date. Protect yourself in a month-to-month lease by having a right of first refusal of another tenant.

Equipment will need to be sold or stored until you can sell or dispose of it. Equipment never gets more valuable, so if you can sell it to a local surgeon, that is usually the easiest transaction. The problem is that you will rarely get someone to take all the equipment. The Internet is providing new methods of bringing buyers and sellers together. Many online equipment companies will handle everything including de-installation, packing, shipping, and training of new buyers, and even providing warranties on equipment.

Prices will vary depending on demand, condition of the equipment, and ease of transport. Generally, a practice will do well to get 25 percent of its purchase price for used items in good condition. Here are the Web sites for some companies that specialize in buying and selling used equipment and excess inventory: www.evergreenmed.com; www.mednetlocator.com; www.medplanet.com; www.medisource.com; www.mediproductions.com; www.1-medical-equipment.com (888/999-4774).

Obviously, all these issues are easier to handle if someone takes over the practice. This can be accomplished by bringing in a new associate or by having an existing practice take over the charts, equipment, and space. In most cases, the retiring physician will not be able to get much for the practice beyond the market value for the equipment and fixtures. Even if such arrangements cannot be made, it may still be economically advantageous to not have the cost of storage and retrieval for medical records.

Q.

What if I just want to slow down?

A.

It can be very difficult to slow down a surgical practice without understanding partners, hospitals, and professional liability carriers. To some extent it is a matter of degree. If someone just wants to stop or reduce the on-call schedule, the burden shifts to the surgeons who are not retiring. Medical staff rules may require any surgeon with active privileges to take a share of call for the emergency department. Either someone will have to take this call or active privileges will need to be relinquished if the practice does not have an exception for surgeons of a set age and seniority.

The malpractice carrier may not distinguish between a full-time and a part-time surgeon. So, even though work and income are less, the malpractice premiums stay the same. Check with the carrier.

In a group practice, having one physician reduce his or her time and productivity may not reduce the overhead at all. Depending on how expenses are shared, it may only serve to shift overhead to others and not create room or opportunities to expand the practice. This action may be tolerable in the short term, but not in the long term. The time to deal with retirement is well before anyone wants to retire. It can be a difficult and unpleasant situation to face when decisions must be made quickly.

Because retirement or slowing down are usually foreseeable, it makes sense to have some provisions for these events. In the interest of the long-term success of the group, though, it is best if the arrangement for slowing down occurs over a finite period. An agreement to allow someone to slow down for 36 months allows a transition time and a target time for replacing the retiring surgeon. □

This column responds to questions from the Fellows and their staffs, and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics that you would like to see addressed in future columns, please contact the Chicago staff of the Health Policy and Advocacy Department, tel. 312/202-5150; fax 312/202-5021; or e-mail HealthPolicyAdvocacy@facs.org.

College leaders awarded honorary Fellowship in Royal College of Surgeons

The American College of Surgeons' two most recent Past-Presidents—George Sheldon, MD, FACS, and James Thompson, MD, FACS—were awarded honorary Fellowship in the Royal College of Surgeons of England (RCS[Eng]) during the organization's bicentenary meeting last October. As part of this event, Drs. Sheldon and Thompson also participated in a press conference with British Prime Minister Tony Blair. The press conference focused on workforce, access to care, and other issues pertaining to England's National Health Service.

Additionally, Drs. Sheldon and Thompson joined in "A National Service of Thanksgiving for the Bicentenary of the Royal College of Surgeons of England" at St. Paul's Cathedral in London. The Archbishop of Canterbury conducted the service, and the Princess Royal, Princess Anne, was in attendance.

During the RCS(Eng) induction ceremony, Dr. Sheldon was honored as "one of those unique individuals who has spanned the American surgical scene over the last three decades, culminating in the Presidency of the American College of Surgeons in 1998." His citation from Christopher Russell, MS, FRCS, also noted that Dr. Sheldon has made exceptional contributions to research in trauma, parenteral nutrition, and liver failure and infection. In his current position



Left to right: Dr. Sheldon, Dr. Thompson, and Mr. Jackson.

as professor and chair of the department of surgery at the University of North Carolina, Chapel Hill, Dr. Sheldon has developed the facility into a major surgical center, Mr. Russell said. Lastly, Mr. Russell noted that Dr. Sheldon has held important positions in many prestigious surgical societies and bodies, including the American Surgical Association and the American Board of Surgery.

In addition, Dr. Sheldon attended the Joint Conference of Surgical Colleges, held in conjunction with the RCS(Eng) Bicentenary Celebration and hosted by Barry Jackson, MS, president of the RCS(Eng). The Joint Conference was founded in 1963 to further un-

derstanding of training systems throughout the world.

Meanwhile, Dr. Thompson, still President of the ACS at the time of the RCS(Eng) meeting, was lauded as "an outstanding academic surgeon of world renown" by Mr. David Rosin, MS, FRCS. Among other accomplishments, Mr. Rosin noted that Dr. Thompson served as professor and chair of the department of surgery at the University of Texas in Galveston for 25 years. "During this time, he built up a superb group of clinicians and scientists who, under his direction, were extremely productive," Mr. Rosin said. He added that Dr. Thompson has been a prolific author of studies on the function of the gastrointestinal system, has been visiting profes-

sor to 220 institutions, has held influential positions in a number of surgical organizations, and has honorary degrees from several international institutions.

The presentation of honorary Fellowships to these two surgeons was one symbol of the ongoing relationship between the ACS and the RCS(Eng). As Mr. Jackson wrote in the October issue of the *Journal of the American College of Surgeons* (pp. 435-440), "The American College of Surgeons...has long had close and cordial association with

the Royal College of Surgeons." For instance, the president of the English College, Sir Rickman Godlee, presented the inaugural address at the ACS's 1913 Clinical Congress and gave the newly formed College "an illuminated parchment scroll of greeting from the other side of the Atlantic." During the 87 years that have passed since that event, "there has been continued close and warm friendship, both corporately and individually—friendship between the two Colleges and between many in-

dividual Fellows," Mr. Jackson noted, as well as "much interchange of scientific endeavor."

This past year, Mr. Jackson presented the opening ceremony at the Clinical Congress. In that presentation, he summarized the history of the RCS(Eng) and concluded by presenting an inscribed copy of *The Royal College of Surgeons of England: 200 Years of History at the Millennium* to Dr. Thompson. Mr. Jackson was named an Honorary Fellow of the College during the 2000 Clinical Congress.

Trauma and critical care meeting to be held in May

The Committee on Trauma of the American College of Surgeons will present Trauma and Critical Care 2001—Point/Counterpoint XX, May 21-23, in Atlantic City, NJ. The Trump Taj Mahal Casino Resort will be the site for the program, which will bring together nationally recognized authorities to address difficult and controversial trauma and critical care issues. The course, sponsored by the ACS Committee on Trauma as a continuing medical education course, will take a broad look at some of the current issues in contemporary trauma care.

The objectives of the course are: to provide a review of the latest developments in the care of the acutely injured patient; to re-examine current diagnostic and treatment approaches and describe alternative methods which take into consideration cost-effectiveness and quality of care issues; to gain a greater

understanding of the latest techniques in the management of commonly encountered thoracic injuries; to present challenging case management scenarios and offer advice regarding difficult diagnostic, therapeutic, and technical challenges; to adopt new technical advances in caring for the injured, including endovascular stenting, laparoscopy, and compartment viability assessment; to recognize the important role of triage in determining patient destinations and the implications of procedures performed in the field; to explore emerging trends as we enter the new millennium and anticipate changes in our management of specific injuries and patient subpopulations; to gain a greater familiarity with certain serious and life-threatening complications that may occur following trauma and learn how to reduce their impact on patient outcome; to learn how trauma

surgeons are trained in Europe, how their training is reflected in their scope of practice, and what implications the European model has for trauma surgery in the United States; and to improve mortality and morbidity by addressing specific conditions affecting patients confined in the ICU.

The scientific program committee consists of Kimball I. Maull, MD, FACS, Course Chair; Charles C. Wolferth, MD, FACS, Course Co-Chair; L. D. Britt, MD, MPH, FACS; David V. Feliciano, MD, FACS; Lenworth M. Jacobs, Jr., MD, MPH, FACS; and Michael Rhodes, MD, FACS.

Complete course information can be viewed online through the American College of Surgeons' Web site at www.facs.org/about_college/acsdept/trauma_dept/cme/traumtgs.html. For further information about the course, contact the ACS Trauma Department at 312/202-5342.

College delegation active at AMA House of Delegates meeting

Five delegates represented the American College of Surgeons at the December interim meeting of the American Medical Association (AMA) House of Delegates: LaMar McGinnis, MD, FACS (delegation chair); Charles Logan, MD, FACS; Richard Reiling, MD, FACS; Amilu Rothhammer, MD, FACS; and Thomas Whalen, MD, FACS. In addition, Chad Rubin, MD, FACS, served as the College's delegate to the AMA Young Physicians Section.

The College introduced several resolutions to the House of Delegates. One of the resolutions, "HCFA Staff Contact for Specialty Societies," asked the AMA to meet with the Health Care Financing Administration (HCFA) to insist that the agency hire a principal physician contact/liaison for medical specialty societies, carrier medical directors, and regional HCFA reimbursement specialists. This physician's main responsibility would be to assist all parties in prompt resolution of issues regarding implementation of Medicare policy and other questions or concerns from all involved parties.

Testimony at the reference committee indicated strong support for the resolution, with many physicians expressing frustration with the difficulty of reaching HCFA staff to resolve Medicare policy questions. The House adopted this resolution.

Another College-sponsored resolution, "Physician Information on Third-Party Payor Performance," asked the AMA to investigate the development of a national data base of information collected from physicians and their offices on third-party payor performance. The repository would house information on topics including, but not limited to, timeliness of payments, denial rates, geographic or market variability in timeliness and denial rates, partial payments and variances from expected payments (given contractual allowances), and grievance settlements.

While testimony during reference committee hearings indicated mixed support for this resolution, the House of Delegates agreed with the reference committee's recommendation to refer it to the AMA Board of Trustees for decision.

Other actions by the House of Delegates of interest to surgeons were as follows:

- *Office-based surgery:* The House referred to the Board of Trustees two resolutions calling on the AMA to study the issue of patient safety in office-based surgical facilities. The resolutions suggested that the AMA examine issues of accreditation, access to care, and the need for guidelines that could be developed. The College was very vocal in promoting its *Guidelines for Optimal*

Ambulatory Surgical Care and Office-based Surgery, and it offered to actively work with the AMA to address this issue.

- *Emergency Medical Treatment and Active Labor Act (EMTALA):* The House adopted a resolution directing the AMA to develop an action plan within 30 days to address continued problems with expansion of EMTALA regulations beyond their original intent. The resolution also called upon the AMA to address concerns that health plans are either inappropriately paying or failing to reimburse physicians and hospitals that provide emergency services to out-of-plan enrollees. To improve policies and regulations with regard to the application of EMTALA, the resolution recommended that the AMA create a work group that includes representatives of emergency medicine, other physician organizations, hospitals, health plans, business coalitions, and consumer groups.

The next meeting of the AMA House of Delegates is scheduled for mid-June. The College's delegation will continue to advocate on behalf of all surgeons. For more information, contact Jon Sutton, Health Policy and Advocacy Department, tel. 312/202-5358, e-mail jsutton@facs.org.

Fellows may register online for Spring Meeting

Interested individuals may now register online (www.facs.org) for attendance at the College's 29th Annual Spring Meeting, which will take place April 22–25, 2001, at the Westin Harbour Castle in Toronto, ON.

To emphasize its strong commitment to and support of general surgery, the American College of Surgeons devotes its annual Spring Meeting to the interests and needs of the practicing general surgeon.

The Advisory Council for General Surgery has planned a program for the 2001 Spring Meeting that should be of interest to all general surgeons. Included in the program will be a number of postgraduate courses in image-guided breast biopsy, including: Breast Ultrasound and Stereotactic Breast Biopsy; Ultrasound for Surgeons; Ultrasound in the Acute Setting; Abdominal Ultrasound: Transabdominal, Intraoperative, and Laparoscopic; Ultrasound Instruction Course; and Surgical Education: Principles and Practice. These courses will provide didactic and workshop experience in these techniques, which have become useful and necessary tools for the modern general surgeon.

In response to continuing calls for verifying surgical competence, the Assembly for General Surgeons on Sunday, April 22, will have as its topic Continued Professional Development: Maintenance of Cer-

tification. The session will focus on new initiatives of the certifying boards in the U.S. and Canada to replace recertification mechanisms with programs to measure and to maintain professional competence. This interactive general session encourages discussion by all in attendance, so that the views of practicing general surgeons on the important issue of physician accountability to patients, institutions, payors, and regulators can be shared.

Panels on endovascular surgery, misadventures in laparoscopic surgery, inflammatory bowel disease, neoadjuvant therapy for cancer, appendicitis, and new directions in cancer care will be complemented by popular didactic courses in minimal access surgery, vascular surgery, and trauma.

The Film Program, featuring highlights of the 2000 Clinical Congress, will round out an exciting spring program.

To enhance the educational value of this meeting, technical exhibits will again be presented. More than 50 companies will present products or services that relate to the practice of surgery.

Hotel reservations

A block of rooms has been reserved at the Westin Harbour Castle for ACS Spring Meeting participants. To make your reservation, call the hotel di-

rectly and identify yourself as an ACS meeting participant:

Westin Harbour Castle
1 Harbour Square
Toronto, ON, M5J 1A6
tel. 416/869-1600, or
1/800-WESTIN-1
(Central reservations,
Canada and U.S.)
fax 416/361-7448
www.westin.com

Single: \$161.00 (Canadian)
Double: \$161.00 (Canadian)

The deadline for hotel reservations is **Monday, March 19, 2001**. After that date, the ACS convention rate will no longer be in effect, and the hotel may charge its regular rates, subject to availability.

The preliminary program will appear in its entirety in the March 2001 issue of the *Bulletin* as well as on the College's Web site. Fellows of the College will be receiving the 2001 Spring Meeting program planner and registration form this month, so watch for it in your mail. Advance registration for the meeting is free for all Fellows, Associate Fellows, and Candidates.

The ACS coding hotline has answered more than 100,000 coding questions.

Have you taken advantage of this membership service?

The College's coding hotline—800/ACS-7911 (800/227-7911)—was established over five years ago to provide Fellows with immediate access to coding specialists specifically trained in procedural coding for your specialty. These specialists have direct access to a dynamic database organized by procedural code, payor, and state. The database is updated on a regular basis.

Since the hotline's inception, calls have increased from 15 per day to more than 50 per day. Because of this growth and in order to continue the quality of service you have received in the past, it has become necessary to adopt stricter guidelines for hotline usage as follows:

- Confirmation of ACS Fellowship is required to obtain Hotline assistance. The Hotline staff will ask that Fellows give their Fellowship identification number when calling the Hotline. Hotline services are provided and measured in Consultation Units (CUs.) One CU is a period of up to 10 minutes with additional 10-minute increments or portions thereof charged at one CU per 10-minute increment. Hotline services are limited to two CUs for each tele-

phone call. Calls over 20 minutes may require private consultation. Each caller will be advised of appropriate consultation fees to conduct said review (i.e., reviewing operative notes, etc.).

- ACS Fellows are given 10 consultation units (CUs) in one 12-month period. Unused consultations will not roll over into the next 12-month period. Additional CUs are available for purchase by Fellows at the prevailing Phy-

sician Reimbursement Systems (PRS) retail price (\$230 per 10 additional units through June 31, 2001). Operative notes are not eligible for ACS Hotline services. Coded operative notes will only be reviewed using individually purchased CUs at the prevailing PRS retail price.

- The hours of operation are from 7:00 am to 4:00 pm (MT), Monday through Friday, holidays excluded.

Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents (B/R) at its meetings held October 21 and 27, 2000:

- The B/R expelled a general surgeon from Michigan. A court found the surgeon guilty of 16 counts of false Medicaid claims, one count of conspiracy to submit false claims, and one count of conspiracy to deliver prescriptions. His medical license was suspended for a minimum period of six months and one day, and he was fined \$5,000.

- The B/R placed a plastic surgeon from Florida on probation. The state charged him with failing to keep written medical records justifying his course of treatment, and practicing medicine below the standard of care. His medical license was placed on probation for one year with six months stayed.

- The B/R placed a general surgeon from Washington on probation. According to the State Commission, the surgeon allegedly failed to perform a splenectomy and closely monitor a patient who had a ruptured spleen, and allegedly misplaced chest tubes and failed to recognize the misplacement. The resulting intra-abdominal bleed-

ing allegedly caused the patient's death. The surgeon's medical license was placed on indefinite probation and he was fined \$3,000.

- The B/R censured an otorhinolaryngologist from Michigan. The surgeon was placed on probation after he allegedly performed a surgical procedure with resultant postoperative complications. As noted by the court, the surgeon failed to conform to the minimal standards of acceptable and prevailing practice for the health profession, whether or not actual injury to an individual occurred.

- The B/R suspended a plastic surgeon from Texas. The Conclusions of Law revealed that he was subject to board action due to his inability to practice medicine with reasonable skill and safety to patients by reason of a mental or physical condition.

- The B/R censured a general surgeon from Ohio. The medical board charged the surgeon with failure to conform to minimal standards of care while performing a laparoscopic cholecystectomy. After a 90-day suspension, his license was placed on probationary terms, conditions, and limitations for at least two

years or until his next 50 laparoscopic surgical cases had been monitored.

- The B/R placed a general surgeon from California on immediate temporary suspension. The surgeon was convicted of aiding and abetting mail fraud and was sentenced to a four-month prison sentence followed by three years of probation with terms and conditions, which includes the first four month of probation to be spent in a community correction component, and payment of a \$200 special assessment.

- The B/R placed a colon and rectal surgeon from Wisconsin on immediate temporary suspension. The surgeon was charged in a one-count indictment alleging that he had used the Internet to attempt to persuade an individual under the age of 18 to engage in sexual activity. The surgeon was ordered to surrender to a federal correctional institution.

In addition, the Board of Regents approved revisions to Article VII, Sections 1 and 2 of the *Bylaws*, which address maintenance of Fellowship and membership. The current *Bylaws* can be found on the College's Web site at www.facs.org.

Surgical oncology bibliography available online

The Society of Surgical Oncology (SSO) has posted the first edition of an annotated bibliography of the important literature on common problems in

surgical oncology online at www.surgonc.org/sso/biblio/biblio.htm. "Surgical Oncology: Yesterday, Today and Tomorrow" is designed to provide sur-

gical oncology fellows-in-training and practicing surgeons with an up-to-date summary of published literature, current abstracts, and ongoing clinical tri-

als focused on various types of cancer.

Specifically, the Web site contains bibliographies related to breast cancer, colon-rectal cancer, endocrine oncology, esophageal cancer, gastric adenocarcinoma, hepatobiliary malig-

nancies, lung cancer, melanoma, pancreas cancer, and soft tissue sarcoma. Each disease site bibliography was prepared by a member of SSO who is an expert on the condition. Each section was then reviewed for content and scope

by other experts in the field. SSO plans to update the bibliography annually and to add new sections as appropriate, including sections on minimally invasive surgery in oncology and head and neck cancer.

Trauma Motion Picture Session: Call for videotapes

Authors of videotapes on subjects related to trauma (such as, "how-I-do-it," operative techniques for interesting or challenging problems in trauma resuscitation or management, and so on) who would like to present their videotapes during the 2001 Clinical Congress in New Orleans, LA, are encouraged to submit all of the following:

- Preliminary information on the appropriate form, available from the Committee on Medical Motion Pictures, American College of Surgeons, 633 N. St. Clair, Chicago, IL 60611-3211; tel. 312/202-5262.
- A 50-word abstract for each videotape.
- The videotape itself (3/4" U-matic or 1/2" Super-VHS formats).

Submit before **April 2, 2001**, to: Rao R. Ivatury, MD, FACS, Dept. of Surgery, West Hospital, 15 East, P.O. Box 980454, 1200 East Broad St., Richmond, VA 23298-0454.

The Trauma Motion Picture Session will take place on October 10 from 1:00 to 3:00 pm. For further information, call 804/828-7748.

Coding workshops

The College will be hosting coding workshops for the first half of 2001. We have a new one-day format, for all surgeons, with a new consultant. The program, Coding and Documentation: The Keys to Reimbursement, will present both CPT and ICD-9-CM coding for surgeons and their office staff that is basic to intermediate. The program will include an interactive networking lunch to assist in meeting other colleagues with similar coding issues. Earn eight Category I CME credit hours.

Dates and locations:	February 22, 2001	Wyndham Anatole, Dallas, TX (program in conjunction with the February 23-24 North Dallas Chapter meeting)
	February 24, 2001	Hilton Ft. Lauderdale Airport, FL
	March 30, 2001	Hilton Crystal City at National Airport, VA
	March 31, 2001	Crown Plaza, Secaucus, NJ
	April 28, 2001	Pointe Hilton at Squaw Peak, Phoenix, AZ
	May 10, 2001	Sinclair Community College, Dayton, OH (program in conjunction with the May 10-12 Ohio Chapter meeting)
	May 27, 2001	Hilton San Francisco, CA
	June 9, 2001	Caribe Hilton, San Juan, PR
	June 22, 2001	ACS Headquarters, Chicago, IL
	June 23, 2001	Lake Lawn Resort, Delavan, WI

For further registration information, contact Diane Mazmanian at 312/202-5406; fax: 312/202-5021; e-mail dmazmanian@facs.org.



Highlights of the Board of Regents meeting

October 20-22, 27, 2000

by John P. Lynch,
Director,
Organization Department

Fellowship

The Regents approved a total of 1,636 Initiates for induction into the College. The Initiates come from the U.S. and its possessions, Canada, and 43 other countries.

Financial reports

The Regents reviewed various reports on College finances and approved the proposed six-month 2001 budget in preparation for the change in fiscal year end to June 30 of each year. Additionally, the Regents approved a Finance Committee action recommending that dues remain the same for 2001. This is the ninth consecutive year without a dues increase. The following schedule of rates for 2001 was then approved by the Board of Regents based on the recommendation of the Board of Governors at its meeting on October 22.

- Domestic Fellows (United States) - \$375
- Canadian Fellows - \$320
- Fellows from other countries - \$155
- Associate Fellows - \$188
- Candidate Group - \$20

In addition, the Board approved the Finance Committee's recommendation that Associate Fellows pay an application fee of \$75 instead of first-year dues of \$188, thereby affording new Associate Fellows a savings of \$113. In another action, the Regents approved the actions taken by its Finance Committee providing \$1.46 million in funding for scholarship and fellowship awards beginning in 2002. Finally, the Board approved the appointment of the national accounting firm of Deloitte & Touche to audit the financial statements of the College for a five-year period beginning with the year ending December 31, 2000.

Revised charge to Program Committee

The Regents approved a revised charge to the College's Program Committee. The new di-

rective includes a stipulation that the committee maintain a relationship with the components of the College responsible for sessions at the Clinical Congress that ensure timely and effective contributions to the planning, development, and conduct of the annual Clinical Congress. The committee must periodically recommend to the Board of Regents funda-

mental changes in the policies and procedures relating to the Clinical Congress to improve its quality and effectiveness.

Revised Clinical Congress schedule

Several recommendations from the Program Committee for revision of the Clinical Congress schedule were approved by the Board. These changes, if feasible, would include moving the Opening Ceremony and Induction of Honorary Fellows to Sunday. These activities would be followed by a reception for the Initiates. The Regents approved this recommendation in the interest of attracting young surgeons and exposing them to the broad representation of the College and to enhance the time devoted to attending scientific sessions.

GME Committee

The Graduate Medical Education (GME) Committee reported that it sponsored a "Day at the American College of Surgeons" during the Clinical Congress in an effort to recruit and retain under-represented ethnic minorities in surgery. Approximately 150 students from Chicago public school mathematics, science, and technology academies were invited to spend a day with a surgeon mentor. More than 50 African-American and Hispanic Fellows and surgical residents spent a full day with these students (two or three per surgeon) and committed to serving as role models for surgical careers. The high school students also

met with a group of senior medical students attending the programs sponsored by the ACS Committee on Surgical Education in Medical Schools.

Candidate and Associate Society

The Regents were informed that the second annual meeting of the ACS Candidate and Associate Society-American College of Surgeons (CAS-ACS) was held on Sunday, October 22, during the Clinical Congress. This included a meeting of the CAS-ACS Council. The initial Council of Representatives of the CAS-ACS has been selected. Currently there are 129 council members representing 50 chapters and 12 surgical specialties in the U.S. and Canada. Council members were nominated by surgery residency program directors, and final selections were made by ACS chapters.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

The report of the ACS Commissioners on the JCAHO Board of Commissioners was presented to the Regents; it indicated that the Board of Commissioners had modified and approved the continuation of reporting option "Alternate 4" under the JCAHO Sentinel Event Policy. This alternate can be used by organizations with significant concerns about sharing certain legally sensitive sentinel event information with the Joint Commission. Under Alternate 4, an organization may opt to have a specially trained surveyor conduct an on-site review of the organization's response to a sentinel event rather than provide a root-cause analysis to the Joint Commission. Under this option, the surveyor conducts interviews and reviews relevant documents to obtain information about the process an organization uses to respond to sentinel events. The chief executive officer of an organization is required to affirm in writing that use of any alternative for review under the Sentinel Event Policy would increase the risk of waiving existing confidentiality protections for the information.

Summary report—

Board of Governors' Annual Reports

The Regents reviewed a summary of the annual reports submitted by the Governors. The summary report outlined the concerns of Fellows regarding specific surgical and health-related issues at the national and local levels and identified specific recommendations for College programs to address these concerns. This year, 230 of the College's 264 Governors (87%) submitted reports.

In addition, the Regents reviewed the Response Report presented to the Governors by Barbara L. Bass, MD, FACS, Chair of the Board of Governors, at the Governors' annual meeting on October 22. The report outlined programs initiated by the College in 2000 in response to the major categories of suggestions that the Governors made in 1999.

Professional liability activities

Among the College's professional liability activities, the newly renamed Committee on Patient Safety and Professional Liability is developing a new patient safety manual and is reviewing the book's proposed contents. The committee also is evaluating the draft policy statement developed by the National Patient Safety Foundation on disclosing medical errors to patients and their families. Committee concerns and suggestions for changes are being presented through the College's representative to the Foundation. In addition, the committee presented a postgraduate course on "Professional Liability in a Changing Health Care Environment" and two panel programs, "The Surgeon and the Law" and "Medical Errors and Improving Patient Safety," at the 2000 Clinical Congress.

Legislative and regulatory update

The Board reviewed the College's legislative and regulatory activities. In July, the College jointly announced the creation of a set of general principles for patient safety reporting systems. These principles were developed by a broad-based coalition of national health care organizations including the College, the Ameri-

can Medical Association, and the JCAHO. They address the need for strong confidentiality protections and information sharing and note that data related to reported events should be comprehensively analyzed and disseminated widely among health care professionals and organizations.

In another reported activity, the College continues its active participation in the Practice Expense Coalition, a group of over 30 medical and surgical specialties that has been lobbying for a legislative remedy to continued payment reductions for procedures as resource-based practice expense relative value units are phased into the Medicare fee schedule. Also, the College has sent legislative alerts to 270 Fellows across the country, including members of the ACS Congressional Action Program, asking them to urge their legislators to pass the Bipartisan Managed Care Improvement Act before Congress adjourns. The outlook for passage of this legislation remains uncertain. The ACS has also submitted comments to the HHS Office of the Inspector General (OIG) on a draft guidance document intended to help physicians in solo and small group practices to comply voluntarily with the anti-fraud and abuse requirements of federal health programs.

Last year, the ACS established its Congressional Action Program (CAP), an initiative designed to develop and strengthen individual relationships between Fellows and congressional leaders and staff in the year 2000 and beyond. The goal of the program is to identify surgeons in several key states who will commit to taking action in support of College-backed initiatives. Washington office staff have visited several chapters in the past year to recruit Fellows for the program. The Regents were informed that close to 200 Fellows participate in the program. Legislative alerts on trauma system funding, managed care reform, physician reimbursement, and collective bargaining have been sent to CAP participants during the last six months, and response rates to these alerts have averaged between 70 and 80 percent.

In another important socioeconomic action, a subcommittee of the General Surgery Coding and Reimbursement Committee met to complete the College's submission to the AMA/Specialty Society RVS Update Committee (RUC) for the five-year review of relative work values and to prepare to defend ACS recommended changes in relative values for 314 general surgery procedure codes.

Consulting agreement with Health Policy Alternatives

The Regents approved renewal of the longstanding agreement with Health Policy Alternatives, Inc. (HPA), through June 30, 2001. HPA, a Washington-based consulting firm, provides the College with health policy analysis and strategic advice.

AMA House of Delegates meeting

The Regents received information on the June 11-15 AMA House of Delegates meeting actions of interest to the College. The ACS submitted a resolution to the House together with its cosponsors, the American Urological Association and the American College of Emergency Physicians, recommending that the AMA support the policy that all appropriately trained physicians be reimbursed for performing ultrasound imaging. The House supported the recommendation of its reference committee that a physician is considered appropriately trained if he or she meets the training and education requirements of his or her specialty.

Commission on Cancer Approvals Program

The Regents received an update on the Commission on Cancer Approvals Program. Currently 1,453 hospital cancer programs are approved by the Commission on Cancer. During the coming fiscal year, 450 surveys are targeted. The field staff program has been restructured to improve survey consistency. Currently, 39 surveyors conduct the on-site surveys, including 17 new surveyors recruited this year. Consistent with the commission's initia-

tive to develop cancer program standards that measure process of care and outcomes, the Committee on Approvals has adopted incorporation of the College of American Pathologists anatomic protocols into the existing standards for policies and procedures that govern cancer patient management and treatment.

American College of Surgeons Oncology Group (ACOSOG)

ACOSOG has continued to expand its membership base and the number of surgeons participating in the active clinical trials. Presently, ACOSOG has eight active clinical trials and expects to open five additional clinical trials in the next four months. The new trials will evaluate the surgical management of patients with brain cancer, biliary tract cancer, melanoma, pancreatic cancer, and prostate cancer. In another action, the Regents were informed and agreed that ACOSOG will relocate to Duke University as of January 1, 2001. The move has been approved by the National Cancer Institute, which provides the majority of funding to support the clinical trials program. The relocation will provide substantial advantages to the operation of the ACOSOG and to its participating surgeons.

Report of Work Group for Trauma

The Work Group for Trauma presented a report to the Regents. The Work Group, consisting of Regents, the current chair, former chairs and former members of the Committee on Trauma, and ACS staff, was appointed by the ACS Executive Director at the request of the Board of Regents to review and analyze the organization, leadership, and the future of the ACS Trauma Department. The work group has met twice, once by telephone conference call, to develop a strategic planning process to evaluate Committee on Trauma activities. The report covered areas such as the Committee on Trauma's access to the Board of Regents, organizational structure, finances, the Advanced Trauma Life Support Program®, state trauma committees and their relationships to

ACS chapters, the central role of the National Trauma Data Bank™, and public information activities related to the College's trauma program. The Board of Regents and the ACS Executive Director intend to use the report in future strategic planning deliberations relating to the Committee on Trauma.

Report of Work Group for Education

The Work Group for Education presented its report to the Board. The group is examining the College's education mission and how it is presently organized. It is conducting an inventory of the ACS education activities, opportunities, and facilities. It will also assess and define external forces that need to be integrated in the education mission and set templates for development of the ACS's future education mission. The work group has contacted the chairs of all standing committees of the College and other organizational components including the Board of Governors and the Advisory Councils for the Surgical Specialties to assist in obtaining input regarding the organization of education activities within the ACS and new education directions that might be pursued. Meetings with College senior staff are also being held. The group expects to create a task force that will include surgical and nonsurgical educators to help define opportunities for the College in the area of education.

Request from Consortium of Doctors Against Handgun Injury

The Board of Regents approved endorsement of several legislative initiatives being proposed by the Consortium of Doctors Against Handgun Injury (DAHI). The ACS recently joined DAHI, a coalition that includes over a dozen national physician organizations, including the American Medical Association and the American College of Physicians-American Society of Internal Medicine. The legislative initiatives include such areas as research, production safeguards, storage requirements, tracing, sales limitations, and increased enforcement and criminal or economic penalties.

Statement Supporting Motorcycle Helmet Laws

A "Statement Supporting Motorcycle Helmet Laws," prepared by the Committee on Trauma's Subcommittee on Injury Prevention and Control, was approved by the Board. The statement will be included in the *ACS Bulletin* (see p. 27) and on the College's Web site.

Office for Evidence-Based Medicine and Clinical Trials

The Regents approved in principle the establishment of an ACS Office of Evidence-Based Medicine and Clinical Trials. This office would be shared by all ACS departments and would be responsible for conducting clinical trials in areas other than oncology, presently being conducted by the ACOSOG. The Regents requested that a business plan be developed and submitted to the Board and the Finance Committee for further study.

Revision of international Fellowship requirements

Updated requirements for international Fellowship were approved by the Regents. The changes provide clarification or additional information, emphasize instructions that are frequently overlooked by applicants, and align with terminology used in similar revised domestic Fellowship requirements.

Addition of and amendments to Bylaws

The Board approved an ACS *Bylaws* addition permitting acceptance of applicants for Fellowship from surgeons age 60-plus and charging those who are admitted to Fellowship dues for an equivalent of five years. The Regents also approved amendments to the *Bylaws* reflecting needed changes in the section dealing with the maintenance of Fellowship.

Web-based interactive CME program

The Board approved a proposal for an interactive Web site continuing medical education (CME) program in the *Journal of the American College of Surgeons (JACS)*. The program will provide 24 yearly CME-1 credits by pro-

viding two questions from two articles each month presented in print copy and on an interactive Web site linked to the new *JACS* Web site.

Development Program endorsements

The Regents approved mission and purpose statements governing the work of the ACS Committee on Development. Categories of investment opportunities and a commitment pledge to donors were also approved. The Board also endorsed a list of naming opportunities for the consideration of potential donors. A development program update indicated that gifts, pledges, and planned gifts for the year through September 16 totaled \$897,813.

Guidelines for collaboration of industry and surgical organizations in support of CME

The Regents approved guidelines developed by the Board of Regents' Committee on Ethics in support of research and CME. The guidelines seek to maximize corporate participation in CME programs while maintaining the autonomy and impartiality of individual surgeons and surgical organizations. They include general guidelines for meetings, research, grants and fellowship awards, and management of funds from commercial sponsors.

Resident research scholarships

The Board of Regents approved six resident research scholarships for 2001-2003, and one Clowes Award for 2001-2006. The resident scholarships of \$30,000 a year for two years are provided to encourage surgical residents to pursue careers in academic surgery. The George H.A. Clowes Jr., MD, FACS, Memorial Research Career Development Award provides five years of support at \$40,000 a year for promising young surgical investigators, and is nonrenewable thereafter. The Regents also approved a new scholarship, the Faculty Development Award for Oncology of the Head and Neck, to be sponsored and funded jointly by the ACS and the American Head and Neck Society. The scholarship will be awarded for a

two-year period at the level of \$40,000 a year to support clinical basic science or translational research in the study of neoplastic disease of the head and neck.

Communications activities

An update on communications activities was presented to the Board. Announcements of the College's agreement with Healtheon/WebMD to provide free access to an online version of *Scientific American Surgery* to all members of the College were mailed in mid-September. Under terms of the agreement, Fellows, Associate Fellows, and members of the Candidate Group will also be provided with a complimentary one-year subscription to WebMD's physician portal, WebMD Practice. Since June, two more ACS chapters have developed an online presence, bringing the number of chapters with Web sites to 28. As of mid-September, the College's Web site was receiving 9,780 hits per day.

Committee on College Archives

A report from the committee indicated that it is studying the feasibility of an ACS heritage center. Long-range plans will include close cooperation with the ACS Committee on Development and with other professional surgical associations in studying this endeavor.

2001 Clinical Congress program

The program for the 2001 Clinical Congress, October 7-12 in New Orleans, LA, was reviewed by the Board.

Committee and council appointments

The Regents approved changes in membership for several College standing committees and specialty advisory councils.

Policy and planning

At the conclusion of the regular session of the Regents' meeting on October 22, a special policy and planning session was held. The session covered the Report of the Health Policy Task Force and a discussion of collective bargaining by physicians and residents.

The Regents reviewed the following specific areas of focus for the College in identifying a strategy to develop and promote health policy issues. These were reviewed by the Task Force in its position paper, "Setting the Agenda: The College's Vision for the Future of Surgery," and presented to the Regents. They are:

- The quality of surgical care.
- The education of surgeons, patients, and the public.
- Surgical research.
- Service to ACS members.
- Advocacy.

In addition to reviewing these areas of focus, the Regents approved the following recommendations of the Task Force.

1. The Regents of the College should establish a permanent Regental Health Policy Steering Committee for the purpose of coordinating activities related to health policy.

2. The College staff should prepare a business plan for developing a Center for Optimum Patient Care, to maintain visible and active participation in clinical trials, evidence-based medicine, and error reduction.

3. The College should consider developing a proposal for establishing a program to provide new surgical faculty members who are first time investigators with start-up research funds.

4. The College should evaluate its current educational efforts, and support the efforts of the Work Group for Education.

5. The College should more completely identify the needs of its members and target services that would address these needs in a meaningful manner.

6. The College should create a mechanism whereby legislative and regulatory issues can be addressed in a timely manner, and issues of public policy can be prioritized.

Chapter news

by Rhonda Peebles, Chapter Services Manager, Organization Department

To report your chapter's news, please contact Rhonda Peebles toll-free at 888/857-7545 or via e-mail at rpeebles@facs.org.

Chile Chapter to host VII Latin American Congress

Juan Hepp, MD, FACS, President of the Chile Chapter, has announced that the VII Latin American Congress of the College will take place May 6-10 in Santiago. Dr. Hepp anticipates that more than 1,000 surgeons will attend. The five-day education program will include a surgical forum with papers, postgraduate courses, panel discussions, and surgical videos. The following types of surgery will be highlighted: laparoscopic, vascular, thoracic, plastic, pediatric, orthopaedic, trauma, and liver transplantation. Faculty members will include six Fellows from the U.S., as well as one Fellow from Argentina and another from Brazil.

For more information about the VII Latin American Congress or to register, visit the Chile Chapter's Web site at: www.cirujanosdechile.cl/ACS_CL/. Alternatively, contact Dr. Hepp at jhepp@alemana.cl.

Important 2001 meeting dates for Chapter Officers

Chapter officers and administrators should mark the following dates in their 2001 calendars:

March 9-11, Young Surgeons Representatives Meeting, Chicago, IL. Staff contact: Jan Fair, 312/202-5354; jfair@facs.org.

May 17-18, Chapter Leadership Conference, Chicago, IL. Staff contact: Rhonda Peebles, 888/857-7545; rpeebles@facs.org.

Note: A pre-conference workshop is planned for May 16.

Ohio Chapter announces new membership service

Last November, the Ohio Chapter announced a new service for its members. Through this service, designed to encourage more communications from members, the Ohio Chapter has arranged for a new

toll-free telephone number. Ohio Chapter members can contact their headquarter's staff in Dayton by calling 877/677-FACS (3227).

Chapter anniversaries

Month	Chapter	Years
January	Northern California	49
	Louisiana	49
February	Arizona	49
	Australia-New Zealand	16
	South Florida	47
	Iowa	33
	Italy	15
	Lebanon	38
	Montana-Wyoming	36
	Eastern Long-Island, NY	33
	Westchester, NY	49
	Peru	24
	South Korea	14
	Washington State	49

Chapters continue to support College funds

During 2000, 18 chapters contributed a total of \$22,500 to the College's Endowment Funds. The chapters' commitment to the various funds support the College's pledge to surgical research and education. Chapters can contribute to several different funds, such as the Annual Fund, the Fellows Endowment Fund, or the Scholarship Fund. The chapters that contributed during 2000 include:

Life Members of the Fellows Leadership Society*: Arizona, Southern California, Louisiana, Maryland, Nebraska, Brooklyn-Long Island (NY), Ohio.

Annual Members of the Fellows Leadership Society: South Florida, Georgia, Hong Kong, New Jersey, New Mexico, Metropolitan Philadelphia, North Texas, Virginia, Washington State.

Contributors: Southwest Missouri, Montana-Wyoming.

*The Fellows Leadership Society is the distinguished donor organization of the College. Chapters contributing at least \$1,000 annually are members. Chapters contributing \$25,000 are Life Members.

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The *Journal* page

Message from the Editor

by Seymour I. Schwartz, MD, FACS, Rochester, NY

The inclusion of two articles that focus on competence in the March issue of the *Journal of the American College of Surgeons* should hardly be regarded as overkill. The development of mechanisms to determine whether a surgeon's current abilities are commensurate with the majority has long been a sought-after goal, a Holy Grail of surgical educators and evaluating boards.

For a surgeon, there are obviously two major facets involved in "competency": knowledge and technical ability. The latter is unquestionably the more difficult to assess. Perhaps virtual reality will open new vistas in this regard. Competency, by definition, is the ability to deal adequately with a subject. For a surgeon, that definition means diagnosis, apprecia-

tion of the disease, realization of the options of therapy and the prognosis, and the ability to intervene operatively.

The assessment of a surgeon's competence must address all of these factors equally. Alexander Pope wrote: "Reason's whole pleasure, all the joys of sense, Lie in three words—health, peace, and competence."

Dr. Schwartz is Distinguished Alumni Professor, University of Rochester (NY) School of Medicine and Dentistry. He is also Editor-in-Chief of the Journal of the American College of Surgeons and a Past-President of the College.

INTRODUCTORY ABSTRACT from the March lead article

Surgical Treatment of Early Stage Breast Cancer in the Department of Defense Healthcare System. John J Kelemen III, MD, FACS; Thomas Poulton, MD; Marc T Swartz; Ismail Jatoi, MD, PhD, FACS. From the department of surgery, St Louis University, St Louis, MO (Kelemen, Swartz), Madigan Army Medical, Tacoma, WA (Poulton), Brooke Army Medical Center, San Antonio, TX (Jatoi).

Background: The choice between breast-conserving surgery and modified radical mastectomy in the treatment of women with early stage breast cancer in the Department of Defense Healthcare System may be influenced by demographic factors.

Study design: The Department of Defense Automated Central Tumor Registry (ACTUR) was queried for women diagnosed with American Joint Committee on Cancer Stage I or II invasive breast carcinoma from January 1, 1986, to December 31, 1996. Univariate analysis and multivariate analysis were applied to the study variables. Year of diagnosis, age at diagnosis, tumor size, type of hospital, geographic region, and local availability of radiation therapy were evaluated with respect to the type of surgical treatment performed. Surgical treatment was either breast conservation therapy (BCT) or modified radical mastectomy.

Results: After excluding women for whom the data were incomplete (n=308), 7,815 women were identified who met study criteria. There was a progressive increase in the use of BCT to treat tumors of all sizes

from 16% to 47% over the 11 years of the study ($p < 0.0001$). BCT was more frequently utilized for smaller tumors (< 2 cm), with an odds ratio of 2.46 (2.20-2.76, 95% CI). In 1996, 54% of women with T1 (< 2 cm) tumors were treated with BCT. Women treated with BCT were nearly the same age as those undergoing modified radical mastectomy (55.5 yrs v. 56.8 yrs, $p < 0.0001$). BCT was used at a slightly greater rate in medical centers than in community hospitals (31% v 28%, $p < 0.0001$). Use of BCT varied among geographic regions from a low of 24% in the southwestern United States to a peak of 36% in the northeast and 40% in hospitals outside of the continental United States ($p < 0.0001$). Local availability of radiation therapy did not influence choice of treatment.

Conclusions: The use of BCT to treat early stage invasive breast carcinoma in the Department of Defense Healthcare System is increasing. But BCT is used less often to treat larger tumors. Regional differences in the use of BCT persist, even after controlling for other factors. Patient age and type of hospital (community versus academic center) appear to exert little influence on the choice of treatment. Local availability of radiation therapy did not seem to influence the choice of treatment. Our data suggest that efforts to promote the use of BCT should target the central and southwestern U.S. Use of BCT should also be emphasized for women with larger tumors (> 2 cm).